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The Involvement of the Public Health Network in Occupational Health and Safety: a Strategic Analysis

Deena White,
Marc Renaud

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**Deena White,
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THE INVOLVEMENT OF
THE PUBLIC HEALTH NETWORK IN
OCCUPATIONAL HEALTH AND SAFETY:
A STRATEGIC ANALYSIS

by Deena White
Under the Direction of Marc Renaud

Commission d'enquête sur les services
de santé et les services sociaux

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D.W.

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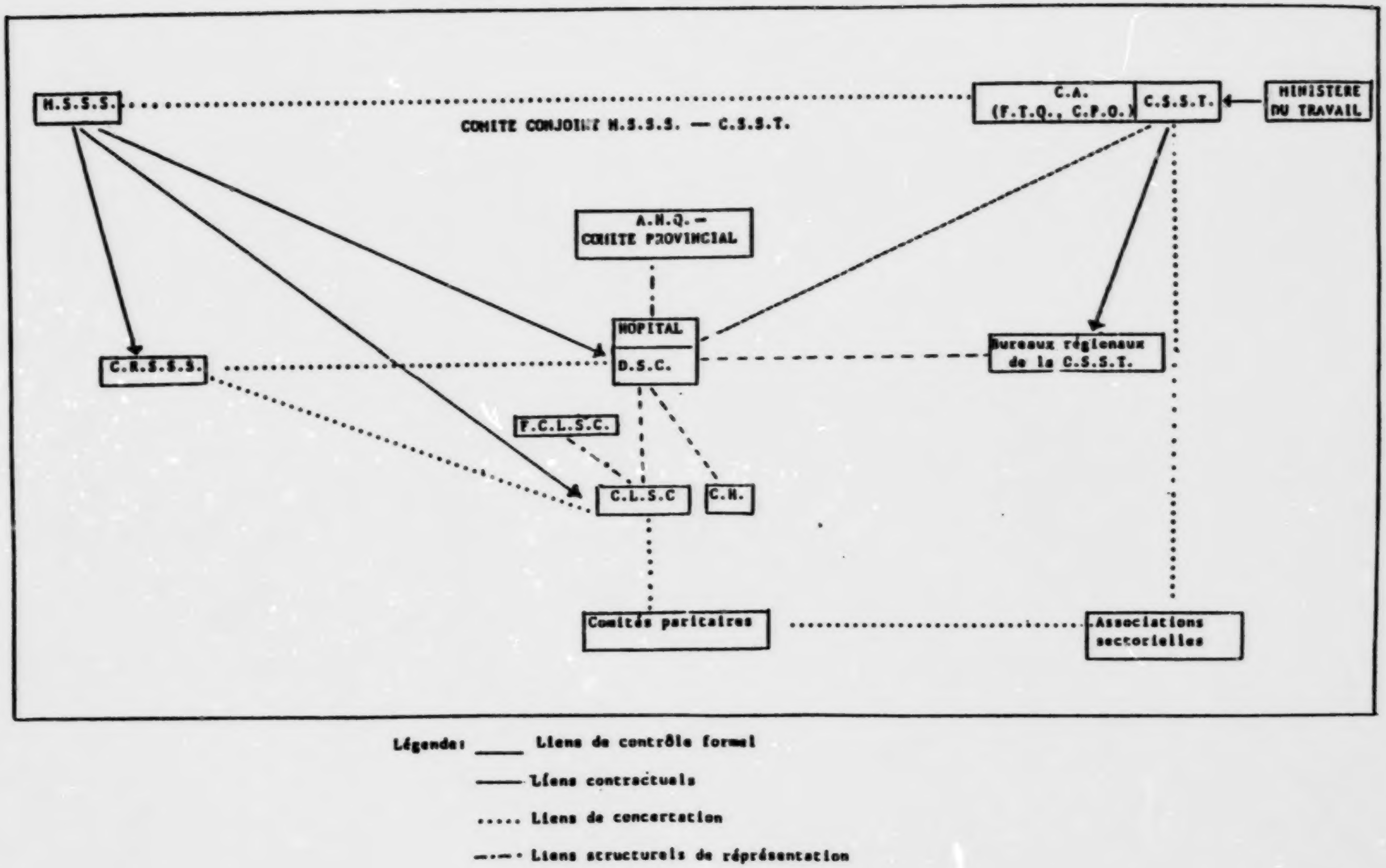
LA SANTE ET LA SECURITE DU TRAVAIL ET SES PRINCIPAUX INTERVENANTS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C.A.
(F.T.Q., C.P.Q.)
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MINISTERE
DU TRAVAIL
A.H.Q. —
COMITE PROVINCIAL
HOPITAL
D.S.C.
C.R.S.S.S.
Bureaux régionaux
de la C.S.S.T.
F.C.L.S.C.
C.L.S.C
C.H.
Comités paritaires
Associations
sectorielles
Légende: ____ Liens de contrôle formel
—— Liens contractuels
..... Liens de concertation
—·—· Liens structurels de réprésentation

GLOSSARY

ADDSC: l'Association des directeurs des DSC
Association of heads of DSC's

AHQ: l'Association des hôpitaux du Québec
Quebec Hospital Association

CAT: Commission des accidents de travail (1928 - 1979)
Workman's Compensation Board (1928 - 1979)

CH: Centre hospitalier
Hospital Centre

CH-DSC: Departement de santé communautaire d'un centre hospitalier
Community Health Department of a hospital centre

CLSC: Centre local des services communautaires
Local Community Service Centre

CPQ: Conseil du Patronat du Québec
Quebec Employers' Association

CRSSS: Conseil régional des services de santé et des services sociaux
Regional Health and Social Service Council

CSST: Commission de la santé et de la sécurité du Québec
Occupational Health and Safety Board

CSST-MAS JOINT STANDING COMMITTEE:

Comité conjoint CSST-MAS, mis en place en 1980 à fin d'échange d'information, incluant des representants de la CSST et le réseau de la santé publique, sous la direction de la CSST.

A committee inaugurated in 1980 for the purpose of exchanging information, including representatives from the CSST and the health network, under the chairmanship of the CSST.

DSC: Departement de la santé communautaire (d'un centre hospitalier)
Community Health Department (of a hospital centre)

DSC's PROVINCIAL COMMITTEE:

Comité provincial en santé et sécurité du travail des DSC, au début affilié à l'ADDSC, et depuis 1986, un sous-comité de l'AHQ.

DSC's Provincial Committee for occupational health and safety, at first associated with the ADDSC, and since 1986, a sub-committee of the AHQ.

FCLSC: Fédération des CLSC
Federation of CLSC's

FTQ: Fédération des travailleurs du Québec
Quebec Federation of Labour

HEALTH AND SAFETY COMMITTEE:

Comité paritaire de la santé et de la sécurité du travail d'un etablissement.

Parity health and safety committee of a work establishment.

LSSS: La Loi sur la santé et les services sociaux (L.R.Q., chapitre S-5, 1971).

An Act respecting Health and Social Services (R.S.Q., chapter S-5, 1971)

LSST: La Loi sur la santé et la sécurité du travail (L.R.Q. S-2.1, 1979)

An Act respecting Occupational Health and Safety (R.S.Q. chapter S-2.1, 1979)

MAS: Ministère des affaires sociales (avant 1986)
Ministry of Social Affairs (before 1986)

MAS COORDINATING COMMITTEE:

Comité provincial de coordonnation en santé et sécurité du travail, mis en place en 1985 par le service de la santé au travail du Ministère des affaires sociales.

A provincial co-ordinating committee for occupational health and safety, inaugurated in 1985 under the chairmanship of Occupatinal Health Services of the Ministry of Social Affairs.

MSSS: Ministère de la santé et des services sociaux (depuis 1986)
Ministry of Health and Social Services (since 1986)

POLITIQUE CADRE:

La Politique Cadre d'administration des services de santé au travail de première ligne (MAS, 1982)

Official guidelines for the administration of front-line occupational health services (MAS, 1982)

SECTOR-BASED ASSOCIATION:

Association sectorielle: une association paritaire industrielle pour la santé et la sécurité du travail.

An industrial health and safety association with parity representation from unions and employers.

CHAPTER I

INTRODUCTION

1.1 The Problem

The outstanding feature of the Occupational Health and Safety Act in Québec is the complexity of the system that it spawned. The involvement of the public health network in this system is but a minor element of the global policy. Out of a total of over one billion dollars ($1 337 353 000) spent in 1985 for compensation to victims, prevention and inspection, preventive reassignment of pregnant and nursing workers, and administrative and miscellaneous expenses of the CSST, the cost of health services was only $33.7 million (2.5%).[1] The public health network, i.e., the DSC's and the CLSC's, received $25.9 million directly, or 1.9% of the total CSST budget. Yet the full complexity of the system, with all its administrative, organizational and political intricacies, intersects with the functioning of the health network and impinges on its internal dynamics. How the establishments of the network have interacted within this environment is the object of the present research.

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[1] CSST, Rapport Annuel, 1985. This amount includes payments to the RAMQ, laboratories, etc. as well as payments directly to the CH-DSC's. Final figures for 1986 were not available at this time, but they will have amounted to approximately $40 million for health services, out of which about $27 million was shared by the DSC's and CLSC's.

Our goal in this document is to describe and explain developments both within and between health sector organizations, in the context of their involvement in occupational health. The key organizations concerned include the DSC's and CLSC's, the AHQ (Association des Hopitaux de Québec/Quebec hospital Association), the FCLSC (Federation of CLSC's), The DSC's Provincial Committee for occupational health, and the Ministry of Health and Social Services (MSSS).[2] Only the DSC's and CLSC's have an "official" role in the system, though there are provisions in the law for the Ministry's prerogative to co-ordinate the network's resources. The other actors have emerged in a constellation of relations based on voluntary association.

The key feature of the context within which these relations have developed, is the high level of uncertainty that existed seven years ago, at the outset of the policy, and still exists to a large extent today. Many aspects of the policy were "experimental" when they were introduced in 1979-80. There was no precedent or experience at that time on which the various actors could rely, to guide their decisions and actions. The CSST was an unknown, despite its former incarnation as the Commission des accidents du Québec/Workman's Compensation Board (CAT). Its decision-making body incorporates political forces (unions and management) to which the health network had never before been accountable. The contractual relation between the CSST and the network was basically an untried structure, and contained many surprises for the network.

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[2] A very peripheral role is played by the CRSSS (Conseils régionaux de la santé et des services sociaux/Regional Health and Social Service Councils) in this dossier since, in the case of occupational health, their usual function is ostensibly the responsibility of the CSST regional offices.

There were other sources of uncertainty: the establishments and professionals of the network had very little expertise in occupational health, and yet they had more than any other organization in Québec at the time, including the CSST. They were all starting together from near-zero in terms of epidemiological, technical and operative know-how. The establishments themselves were still quite new. The DSC's had been created only six years before the Occupational Health and Safety Act was adopted; the CLSC network was still far from complete, and under the auspices of the FCLSC, was attempting to reform its reputation and ensure its expansion. Given this reality, the actors were faced with a structure in December, 1979, that still required substantive definition and development. In other words, there was potentially plenty of room for manoeuvering.

Given this context, systemic developments during the first five or six years could best be characterized by the effort on the part of each party involved to appropriate a favourable position for itself within the system. By "favourable", we mean 1) recognition as an indispensible element of the system, and 2) sufficient autonomy to control the attainment of its own objectives within (or beyond) the system. The objective of this project is to show how an original structure, designed to absorb the social forces mentioned above, is transformed by the actors' own definitions of the situation and the strategies that they develop.

Some of the unintended developments that have become issues for the functioning of the network include:

- Ambiguity as to whether the network is accountable primarily to the Ministry or the CSST.

- Constraints on the network in having to comply with two very different organizational cultures and "game rules", those of the network and those of the CSST.

- Parallel linkages between the network and the CSST, one formal, the other informal.

- Exaggeration of competing interests between the DSC's and CLSC's.

- Difficulties in recruiting and retaining occupational health doctors.

- A "contest" between the AHQ and the Ministry over leadership of the occupational health dossier.

- Lack of credibility of the MSSS with respect to the occupational health dossier.

1.2 Scope of the Study

This project unfortunately has severe limitations in scope, imposed by the small amount of time available to prepare the research, gather the data, synthesize the information and write up the document. The same complexity that makes the case of occupational health an exceptionally rich one, in terms of bringing organizational strategies to the surface, underlies these limitations.

We have pointed out that the role of the health network in occupational health policy is relatively small - an auxiliary to the CSST's Department of Inspection-Prevention. But as such, the internal and environmental dynamics of the CSST itself impinge on the functioning of the DSC's and CLSC's in this dossier. These dynamics are both bureaucratic and political, given the two-tiered administration of the CSST. Unfortunately, time constraints made an analysis of the CSST beyond the scope of this research. Nor have we examined the relations between the DSC's and the regional bureaux of the CSST. Likewise, we did not attempt an analysis of the dynamics of the work milieux, including the relations between workers, employers, health and safety committees, sector-based associations and so on. Ultimately, we did not focus on the relation between the public health sector and the private sector.

The fact that these dynamics are being played out in adjacent arenas was kept in mind at all times, but there is much work that remains to be done for a highly nuanced understanding of the system as a whole. In this document, we have focused as closely as possible on one element: the public health sector. Alone, it is a complex system, which in this case interacts with the occupational health system in a highly charged association.

1.3 Outline of the Document

The results of the analysis have been presented in the following format: After a discussion of the methodology that guided the research and the analytical framework (chapter 2), the key institutional actors of the system are briefly introduced (chapter 3). Next, we describe the social origins of the occupational health system, which account for its structure (chapter 4), followed by a cursory history of events from the adoption of the Occupational Health and Safety Act to the present time (chapter 5).

The analysis proper begins with chapter 6. Here, and in chapters 7 and 8, we examine in detail three distinct but interacting processes: first, the decentralization of front line occupational health services to the CLSC's; second, the rapprochement of the DSC's and the AHQ; and third, the polarization of the network along "ideological" lines.

In order to orient the reader, we have attempted to diagram the primary relations that will be discussed in this report (See page vii). Although it was impossible to be faithful to the nuances and informal intricacies of the system, it may be useful to refer to this diagram, and to excerpts from the Occupational Health and Safety Act which are to be found in Appendix "A". Appendix "B" is a point-form chronology of the major events marking the development of the system.

CHAPTER II

AN ANALYSIS OF STRATEGIES: ORIENTATION AND FRAMEWORK

2.1 The General Approach

The methodology adopted for the present research rests on an analysis of the subjective realities of the key actors in a system, with a view to understanding the basis for their decisions and actions.[3]

Through the terms in which they define the situation, and define their own and others' objectives, positions and strategies, we are able to develop an image of the conflicting realities that lie behind a relationship between two or more individuals, organizations or systems. This understanding helps in turn to explain the development of compromises, conflicts and alliances which influence the functioning of the system.

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[3] For further clarification with respect to the approach presented in this section and in section 2.3, refer to the work of Crozier & Friedberg (1977), E. Friedberg (1972) or P. Bernoux (1985).

Although we refer mainly to the subjective realities of the actors, this is not to deny the existence of "objective" (or external) constraints - economic, political, historical and so on. But economic or political conditions affect actors differently, depending on their own positions in the system. Strategic actors themselves are highly aware of the constraints on their own decision-making, and incorporate them into their own definitions of the situation and analyses of their margins of liberty. To the extent that they shape the system by means of their decisions and actions, their own interpretations of external constraints are important to know.

An assumption of this methodology is that these key actors' strategies are "rational" in the sense that they focus on objectives and the means of attaining them. This does not imply, however, that the functioning of the system as a whole is rational. On the contrary, due to conflicting perceptions among the many actors, both individual and organizational, and their divergent objectives and resources, the combination of rationalities often results in a system that is itself quite "irrational". The result may be a diversion from the original goals of the system, or a complete breakdown in which little is accomplished. On the other hand, informal adjustments may result in a system that does not function as planned, but none the less functions well. There is no "one right way" to be successful.

2.2 Operational Objectives

On the basis of these general orientations, and given the scope of the study which limits it to the relation between the CSST and the health network, and among the establishments and organizations of the network, the specific aims of the research are:

1. To identify the **key individual and organizational actors** in the CSST-health network system, and their various "definitions of the situation".

2. To locate the **key resources** (e.g., expertise, authority, finances, allies) and identify who has access to what, and how.

3. To establish the **strategies of the actors**, and the sources of constraint or margins of liberty which condition these strategies.

4. To account for the **relative success or failure** of the various actors' strategies, and to identify the consequences for the system.

5. To develop, on the basis of the above dynamics, hypotheses which **explain the global functioning** of the CSST-health network system, and suggest scenarios for change.

2.3 Data Collection

The research activities associated with this analysis took place over a period of nine months. There were three elements to the research process: 1) the collection and analysis of documentation, 2) interviews, and 3) the synthesis of information.

2.3.1 Documentation

To begin with, documentation regarding the history and functioning of the occupational health system in Québec, with a focus on the health network, was procured from a range of sources, including the CSST, the Ministry of Health and Social Services, the Federation of CLSC's, the AHQ, the Quebec Medical Association, the Quebec Public Health Association, and others. Also amongst the first documents obtained were the sixty-nine briefs presented at the Parliamentary Hearings on the

White Paper, in 1978-79, and the transcription of those hearings. These were analyzed with a view to identifying the key actors of the system, and their respective positions with respect to the policy.

Another early activity was the elaboration of a detailed chronology of the system (Appendix "B"), based to a large extent on the above-mentioned documentation, as well as daily press clippings for the period from 1984 to the present. Together, these steps contributed to the identification of the major issues. Of considerable help in this phase of the research were five interviews carried out with "ex-participants" or "observers" who provided historical information, names of key actors who had not necessarily appeared in the documentation, and their own view of the major issues from a knowledgeable, but somewhat "disengaged" position.

The bulk of the documentation used in this research, however, was obtained during interviews with the key actors themselves. Included here are monographs, working papers, minutes of meetings, proposals, evaluations, presentations, communiqués, correspondence and so on, much of which is of a confidential nature. Verification of verbal statements was often available in documented sources, which the interviewee would provide to support or elaborate on the issue under discussion. In all, over 200 such documents were read.

The readers will notice that there are relatively few formal in-text references in this document. The primary data for the study came from interviews rather than written documents. The documents were essential material for orienting the researcher and for verifying the information received during interviews. However, the material presented in this text is a synthesis, not a report of data. To piece together the documented threads that lead to conclusions, interpretations or speculation would make for an impossibly dense text.

Identifiable and non-confidential documents of particular interest appear in the Bibliography in Appendix "C". These would give a fairly good idea of the positions being taken by the various actors in the system. Recommended are the collections of presentations of the various colloquia. Where a "statement of fact" is made in the text, the source is usually indicated in place (e.g., the Occupational Health and Safety Act, the Politique cadre d'administration des services de santé au travail du première ligne, the CSST Annual Report, etc). Where the verification of statements could only be made by reference to letters, memos, a work paper or confidential document, the specific reference is not made.

2.3.2 Interviews

Thirty four individuals were interviewed during the course of this research. The majority of interviews lasted from two to three hours, with a few that were shorter and some that were longer. Almost half of the interviewees were consulted a second, third or fourth time by telephone, and in five cases, a second interview took place. The respondents were either influential actors in the system, who may have participated in more than one capacity over the years, or they represented a specific organization, association, profession or other position in the system.

The objectives of the interviews were 1) to learn the respondents' perception of the development of the system and its current functioning, and 2) to learn about their particular position in the system - usually related to the organization of which they are a member, and the level at which they participate - and to learn about the resources to which they have access, the margin of liberty they have in their relations with others, and the constraints they face in attaining their objectives.

The interviews were of an informal nature, in the sense that no more than a rough guideline was consulted during the discussions, to ensure that previously identified issues were addressed. The interviewees' straight account of events was expanded by their responses to the question why?, and they were encouraged to raise the issues that were of central importance to them, and to explain their context.

We would like to be able to say most individuals who play influential roles in the functioning of the occupational health system were contacted. This is not quite the case. On the one hand, at least two individuals in a responsible position associated with every institution and organization in the health sector were interviewed, if that institution plays even a peripheral role in the occupational health system. A small number of individuals from the CSST "central" were also met. However, representatives of the unions, the employers, the health and safety committees, the sector-based associations and so on were not consulted, despite their influential role in the development of the system. This was a limitation imposed by time constraints, and the necessity of placing boundaries on the scope of the research.

There was, however, another constraint. The fact that this research was being carried out at a time when changes are in the air, legal reforms are pending, and decisions are about to be taken means that certain individuals were in highly sensitive positions, and were unable to speak out about their current perceptions or activities with respect to the occupational health dossier. Although there were three or four such cases, their absence from the "sample" is not critical. Essential information was obtained by attending colloquia where they spoke or from documents. While this type of information is more "official" than what is often obtained in an interview, at moments such as this, the "official story" is what would have come out in the interview, as well.

2.3.3 Synthesis of the Data

This was an on-going element of the research process. Each new interview was partially based on a synthesis of those that came before it. However, after a "saturation point" had been reached with respect to information about the system, that is, when interviews began to be repetitious, and to offer no new information, the task was to conceptualize the sorts of relations and the patterns which may be identified as "key features" of the system. These were then applied to the present situation, in an effort to suggest some possible consequences of various reform strategies. The results of the synthesis are presented in the concluding chapter of this text. In the following section, the analytical framework that generated the conclusions is explained.

2.4 The Analytical Framework

As assumption of an analysis of strategies is that the decisions of certain key actors in various positions within a system determine, to a large degree, the developments within that system. This is not to say that events proceed from such decisions as planned. On the contrary, a number of decisions are being taken at any given time with respect to the same or related issues, but each of these reflects the position of a different group of actors, and therefore a different definition of the situation, different objectives, and different resources to call into play in order to implement the decision.

At any point in the decision-making process, the pivotal elements are the relations between actors who have a stake in the outcome. Their relative access to resources such as money, legal authority, political influence, information, expertise, and in some cases moral authority, determines the power relation between actors, and the capacity of one to impose their will against the will of others. These "power struggles" are played out at each stage of the decision-making process: the definition of the problem, the development of alternative solutions, the choice of a solution, and the implementation of the decision.

In our study of the involvement of the public health sector in occupational health and safety, we were faced with a dilemma regarding the framework for analysis. First, there was the multiplicity of decisions that were being made during the same time frame, which were partially distinct yet impinged on each other in important ways. We may picture this as a series of interlocking "games", and one alternative was to focus on each of the "games" separately. Second, there was the constraint of having to maintain some sort of chronological sense to the presentation, so as not to lose the readers in a maze of abstract linkages. Another alternative, then, was to present the analysis simply as an "annotated history". As is often the case, the final decision represented a compromise between these alternatives.

We have chosen to analyze three somewhat distinct processes, related to three different decisions: 1) the Ministerial decision to decentralize the health network and transfer all frontline services in occupational health to the CLSC's; 2) the decision of the DSC's to join forces with the AHQ, after years of contention between them; and 3) the "non-decision" within the network regarding its orientation in occupational health - that is, the "debate" over efficient management versus a "community approach".

These three decisions are sequentially linked to each other, though their time-frames overlap. The "decentralization" decision was in part responsible for the DSC-AHQ "alliance". And the debate over alternative orientations represents a polarization of the network which is in part a result of that alliance. By examining each of these issues individually and sequentially, we have been able to specify the linkages between the three, and to take the time overlap into account. But to preserve some chronological sense, we chose not to analyze the entire decision-making process in each case.

Rather, we examined :

1) the implementation of the "decentralization" decision;

2) the determinants of the AHQ's and DSC's decision to formally ally themselves; and

3) the implications of the alternatives within the network with respect to the orientation of the occupational health program.

2.4.1 The Decentralization of Front-line Services

The decision to complete the CLSC network through the decentralization of resources from the DSC's and CSS's was taken by the government on the eve of the 1981 election. With respect to the DSC's especially, this was not so much a new decision, as a commitment to proceed with certain transfers that had been foreseen and specified (as far as possible) at the time that the DSC's were created in 1973. Although the Occupational Health and Safety Act was not to be adopted for another six years, the plan had been to eventually transfer all front-line services to CLSC's, as they were established throughout the province.

Rather than examine the factors related to taking this decision, we have chosen instead to analyze the implementation phase, that is, the repercussions that this decision had in terms of adjustments within the network. In the case of occupational health, the implementation of the policy began with the distribution, in 1982, of the Politique cadre d'administration des services de santé au travail de première ligne. The analysis will focus the Politique cadre, and on the decentralization process as it actually occurred.

2.4.2 The DSC-AHQ Alliance

The history of relations between the DSC's and the hospital administrations suggests that the interests of the DSC's and the AHQ would be unlikely to coincide. Indeed, the DSC's were represented by their Association of Directors for a number of years, and refused to recognize the AHQ as their "voice". In occupational health and safety, the DSC's had created their own Provincial Committee to handle both professional and administrative issues. However, in 1986, the functions of the ADDSC and the Provincial Committee were integrated into the AHQ organizational structure.[4]

In this case, we will examine the factors that determined the choice that was made by the DSC's. The analysis will focus on 1) the situational problems that the two organizations faced, and 2) the role that the alliance was expected to play in the resolution of those problems. One significant aspect of the choice is that it was related not to developments in DSC/AHQ relations per se, but to relations between the DSC's and both the CSST and the CLSC's on the one hand, and relations between the AHQ and both the CSST and the Ministry, on the other.

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[4] The ADDSC continues to exist purely as a professional association of 32 DSC directors.

2.4.3 The Debate Over Network Orientation

There have always been opposing ideological visions of the role of the public health network in occupational health, from 1970's when reforms and legislation were first being contemplated. One vision relates to scientific expertise in epidemiology, industrial hygiene and so on, and to the leadership role that the network would take on the basis of this expertise. The other vision relates more to the appropriation (la prise en charge) of prevention by the people in the work milieux, and the role of multidisciplinary intervention in supporting the development of this responsibility.

This is a debate of words and actions that will ostensibly result in some decision being taken with respect to the network's "official" orientation. Currently, the alternatives have been defined and their consequences are being weighed, but the Ministry has yet to endorse either vision. In the analysis of this debate, we have focused on 1) the objectives of the various actors in taking their particular stand; and 2) the stakes in the debate, at the level of professionals, organizations, and the system as a whole.

CHAPTER III

AN INTRODUCTION TO THE KEY ACTORS

3.1 The Occupational Health and Safety Board (CSST)

The CSST was officially created on March 13, 1980, in accordance with Chapter X of the Occupational Health and Safety Act (LSST). It was to replace the Workman's Compensation Board (CAT), which had functioned since 1928 almost exclusively as a public insurance agency financed through employers' fees. In fact, the president and vice-presidents and most of the staff of the CAT remained with the CSST, and a large proportion of the CSST's functions continued to be related to the administration of the old Workman's Compensation Act, until May, 1985, when the new Act Respecting Work Accidents and Professional Diseases was adopted.

However, there were major differences between the CAT and the CSST. The first President and Director General of the CSST, Robert Sauvé, had been associated with the CAT for only two years before the passage of the LSST, and had been appointed with a view to preparing the CAT for impending changes. Also, the LSST mandated the CSST to involve itself in prevention to a much greater extent than had ever been the case with the CAT. In order to encourage the necessary switch in orientation, Pierre Marois, Minister of State for Social Development and the person responsible for occupational health policy, had authorized several hundred new positions for the CSST on the condition that an equal number of positions be eliminated during the first year of operation. Thus there was indeed an influx of new, expertly trained and often idealistic professionals in place at the birth of the CSST, many of whom had been plucked from the public health network. The fact that most did not stay there for long is an issue that is briefly addressed elsewhere.

Moreover, the internal structure of the CSST differed significantly from that of the CAT, especially with respect to

> a) the composition of it's board of directors, whereby ultimate decision-making power now lay with representatives of the major labour unions and the major employer associations; and
>
> b) its twelve regional offices, which have no decisionmaking powers, but are responsible for most direct relations with the other actors in the health and safety system, notably the DSC's, the sectorial associations and the individual work establishments.

The mandate of the CSST, in brief, is the administration of all aspects of the LSST, including the adoption of all regulations required for its implementation. The decision-making process within the CSST may be characterized as "politico-legalistic": objectives are defined through political negotiation at the level of the board, and the criterion for defending possible solutions is their legality in terms of the LSST.

The mandate of the CSST gives it responsibility for prevention, health services and inspection, as well as compensation. The justification for creating a single structure to administer all these mandates lay in a general consensus regarding the need to reverse the chaotic situation which had existed prior to 1979, where these mandates were splintered and dispersed through dozens of government organizations. But the "double mandate" of the CSST (prevention/compensation) had been opposed by many other individuals involved in the elaboration of the LSST, especially those consultants from the Department of Social Affairs and the health network. Opposition was mainly on the grounds that prevention - the promotion of health in the workplace - could never attain the priority it required if administered by what was essentially an "insurance company", financed by employers. The vastness of the CSST mandate was also opposed on the grounds that it created the potential for an over-sized, over-centralized, and over-bureaucratized structure, no more in touch with the reality of the workplace than the CAT had been.

From the beginning, then, the CSST was mistrusted by the health sector, due to its "parentage" (CAT), its "conflict of interests", its centralized and far-reaching authority.[5] In turn, the CSST had no confidence in the support and cooperation of the public health sector. Although Marois shared a skeptical view of the efficiency of MAS, he had to reject the establishment of a "parallel health system" under the direct authority of the CSST due to the high cost of duplication. But the CSST now perceived the role accorded to the public health sector to be a major compromise and irritant.

The upshot was that the CSST felt it had failed to obtain the control it required to fulfill its mandate, while the public health sector felt it had lost "rightful" control over occupational health. These definitions of the situation remain intact today.

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[5] Some DSC professionals were optimistic at first and joined the ranks of the CSST. Most, however returned to the health sector after one or two years, citing their lack of influence on the orientation of the CSST with respect to prevention, as the major cause.

3.2 The Department of Health and Social Services (MSSS)[6]

With the passage of the Act respecting Health and Social Services (LSSS) in 1971, the Department of Social Affairs (MAS) was established. By the same legislation, a reorganization of health and social service facilities throughout the province was imposed, creating a network of autonomous, but complementary institutions. The network includes hospitals, social service centres, chronic care centres, CLSC's and Regional Health and Social Service Councils, ideally integrated via their complementary roles and functions rather than via a hierarchical structure.

From one angle, the Ministry is considered a part of this network. It's particular responsibility is to ensure the implementation of government policy through province-wide planning and co-ordination. From another angle, the Ministry is not a part of the health and social service network, but rather a part of the government, the State. In this capacity, it is responsible for the development of policies which the network then implements. This dual nature of the Ministry favours a climate in which the institutions of the network may defend their autonomy vis a vis the Ministry, and call for limitations to government intervention in their internal affairs. But since the Ministry has direct access to the regulatory and legislative power of the State, there is also a tendency for the institutions of the network to expect it to be the defender of their interests within government decision-making circles.

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[6] Note that both "MAS" and "MSSS" are used to refer to the Ministry of Social Affairs, called the Ministry of Health and Social Services since 1986. The time period being referred to in the text dictates which term is used.

The dual role of policy-making and policy implementation is not unusual for a government department, and the uncertainties associated with it are well known: between the social reality within which the network operates, and the political reality within which the government operates, communications often break down. Information passed upward from the network is often irrelevant to political decision-making, while policy statements passed down from the Minister's office seldom respond to the concerns of those who work "in the field". There is no direct communication, in this case, between Occupational and Environmental Health Services of MAS, and the decision-making levels of government, including the Deputy Ministers, the Minister, the Council of Ministers, and the Prime Minister. Somewhere between the levels of Director and Assistant Deputy Minister, information gets filtered and translated, and administrative and political concerns either mesh, or don't.

Besides these general characteristics, the role of the Ministry in occupational health and safety policy is particularly ambiguous. In the LSST special status for MAS is recognized: it is granted an observer's seat on the board of directors of the CSST (LSST, art. 145), and the right to approve the model health program and the standard contract between the CSST and the CH-DSC's (LSST, art. 107). Further, the LSST recognizes the responsibility of MAS to "co-ordinate the implementation of health programs and see that the personnel employed is properly qualified and that the equipment and premises used for the purposes of occupational health and safety are of the proper quality" (LSST, art. 167 (16)). Yet it charges the CH-DSC's _directly_ with the responsibility for providing health services (LSST art. 109); it charges the physician in charge of a work establishment (the _médecin responsable_) directly with the responsibility of ensuring the implementation of health programs; and it gives ultimate authority over the form and content of these programs to the CSST. Furthermore, the Standard Contract drawn up by the CSST in 1980, and signed by MAS, effectively "delegates" MAS's coordinating role to the DSC's.

The role of the Ministry in the occupational health dossier is not only ambiguous in terms of it relationship to the network and to the CSST. It is also ambiguous at the political level. Since the election of the Liberal government in 1985, important changes with respect to health and safety policy have been anticipated. The Director of the CSST has been replaced, the vice-president for prevention and inspection has resigned, and the Minister of Labour has promised major reforms in the law. This is a dossier where the MSSS is officially a minor auxiliary; it is not responsible for reforming the policy. Yet it is responsible for defending public health issues, and occupational health has been defined, in law and more recently by the Minister of Labour himself, as a public health issue.

3.3 The Departments of Community Health (DSC's)[7]

The Departments of Community Health were legally defined in 1973, two years after the adoption of the Act respecting Health and Social Services (LSSS). In a sense, the DSC's were an "afterthought" to that reform. The leaders of the movement to create the DSC's were a cohort of young and often idealistic doctors, who had returned to Québec after having been trained in public health in Canadian, American and European universities during the 1960's and early 1970's. Their objective was to establish centres of scientific expertise in matters of public health across the province.

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[7] The DSC's legal designation is "CH-DSC", referring to their status as an administrative department of a hospital centre.

In 1971, the McDonald Commission was established to make recommendations for the integration of municipal public health units (unités sanitaires) into the new health and social service network. As a result, 32 DSC's were established across the province. The personnel from the public health units, mainly nurses and a number of doctors, were transferred to the DSC's, but the orientation of the DSC's and the role they were to assume in the network and the society was defined more by a small vanguard of community health specialists.

Structurally, the DSC's are usually attached to a hospital centre[8] and fall under the authority of the hospital administration and its board of directors. This integration had been a source of controversy, since many individuals had felt that the community health orientation towards populations, prevention and long-range objectives would be overwhelmed by the individualistic, treatment orientation of the hospital. However, there were gains to be made in prestige and credibility for the new field of community health through such an attachment.

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[8] Two DSC's, at Rouyn-Noranda and Cote Nord, are attached instead to the Regional Health and Social Service Councils (CRSSS). These DSC's are not legally represented by the Quebec Hospital Association (AHQ), chief negotiator for the CH-DSC's.

For some time, the DSC's managed to retain a degree of autonomy on the basis of their uniqueness within the hospital. But politically, they represent a stake for both the AHQ and the MSSS. Until recently, they did not acknowledge the Quebec Hospital Association (AHQ) as their official representative. Instead, the heads of DSC's formed their own association, the ADDSC, which often clashed with the hospitals over divergent professional and social priorities. However, today the DSC's and the AHQ speak with one voice. The basis for the rapprochement will be discussed in detail in Chapter VII.

In 1979, with the adoption of the LSST, the DSC's were assured a secure role in the occupational health system: the doctor in charge of health services within an industrial or commercial establishment (the *médecin responsable*) must be certified by the DSC, and the head of the DSC is ultimately responsible for the implementation of the service contract between the CSST and the DSC, as well as the subcontract between the DSC and a hospital centre or CLSC. Thus the CH-DSC - not MAS, nor the health network in general, nor the private physician - is ultimately responsible for the health programs and health services guaranteed by the law. Their Provincial Committee for occupational health, associated with the AHQ, plays a leadership role in coordinating the dossier.

3.4 The Québec Hospital Association (AHQ)

Although the Quebec Hospital Association has existed for over a hundred years, the origin of the modern AHQ coincides with the State-led rationalization of health services in the early 1970's. A major aspect of this rationalization was the reorganization of hospital services, including the closing of some hospitals, the changing of vocation of others, a redistribution of specialized services between hospitals, and the imposition of a more stringent "accountability" to the major funding agency, i.e., the government.

In the years previous to this intervention, Québec hospitals had evolved from being privately-funded, community or religious sponsored institutions, to a point where they relied more and more heavily on government funding. The reforms effectively turned these once-independent establishments into publicly regulated institutions whose regular functions were fully budgeted for by the Ministry. The LSSS allowed for continuing participation of community members in decisions pertaining to the running of the hospital, through the boards of directors, but the same law defined the hospital centres as part of the newly created health network, which was ultimately "coordinated" by MAS. Thus, the LSSS changed the rules of the game between hospitals and government, and between hospitals and other establishments.

It was in response to these developments that the AHQ reorganized in 1971. The Ministry of Social Affairs was now making decisions that affected hospitals in general, as opposed to individual institutions; the hospitals mandated a single voice to negotiate terms and defend their common interests to MAS. The fact that this organization came into being for the express purpose of contesting the nature and extent of MAS intervention in what had been a private domain, is of primary importance in understanding the position occupied by the AHQ in occupational health and safety. It is also significant that public health in particular has been considered a strategic "battleground" for the AHQ and MAS; it is in this arena - the DSC's - that hospital control and Ministry control come into direct confrontation. And in the particular case of occupational health, of pivotal importance was the fact that the AHQ was originally - in its capacity as an employer's association and a member of the CPQ - a voting member on the CSST's board of directors. It had a greater affinity with the CSST than with the Ministry.

Before examining the role of the AHQ in occupational health, then, the confrontation over the DSC's requires further clarification. The problem arises from the fact that the DSC's are at once hospital departments and regional public health units. Public health, before the belated creation of the DSC's, had always been foreign to the individualistic, curative orientation of the hospital. It had instead fallen under the auspices of municipal or provincial governments, and was administered by a few epidemiologists working within a civil service environment and culture. When the public health units became Hospital Departments of Community Health in 1973, they did not immediately shed their close relationship with the civil service. Public health was still seen a government responsibility, and at that time, it would be safe to suggest that the Ministry understood the character and significance of public health better than did the hospitals.

Indeed, MAS clearly assumed the DSC's to be "their'" establishments by virtue of their regional role, and special mandates flowed from the Ministry directly to the DSC's, often bypassing the hospital administration. The direct relationship between the DSC's and the Ministry was denounced by the AHQ as government interference in the internal affairs of the hospital, a threat to hospital autonomy, and to the authority of the hospital administration. The perception of the AHQ was that the DSC's were providing a means for the civil service to extend its bureaucratic reach into the hospitals.

Since the adoption of the LSST, the "traditional" tension between the DSC's and the AHQ has dissipated. This is a significant development, and implies organizational change on the part of both the DSC's and the AHQ. For a series of reasons which are discussed elsewhere, the DSC's mistrust of the AHQ was ultimately laid aside, while the AHQ decided that a stronger recognition and representation of community health within the hospital association would be strategically opportune. In 1985-86, a reorganization within the AHQ created a series of committees under the Community Health Division, including one which incorporated the DSC's Provincial Committee for Occupational Health. This has had a considerable effect on the balance of power within the network.

3.5 The Local Community Service Centres (CLSC's)

The CLSC's came into being by virtue of the LSSS in 1971. A network of CLSC's has been slowly and unsteadily established over the last fifteen years. Although many of the early CLSC's had direct roots in the popular clinics and community centres of the late 1960's and early '70's, they are for the most part "original" establishments offering a wholly new type of service; they do not represent a reorganization of existing institutions, in the manner of the DSC's, which reorganized and replaced municipal public health unit. Although their role has evolved considerably since their inception, the CLSC's are responsible for carrying out front-line community health programs, and for meeting other front-line health and social service needs as may be identified at the community or provincial level.

The very slow development of the CLSC network is central to an understanding of the position of these establishments in the health and social service system. The fact that CLSC's did not yet exist in every community created administrative problems which were more or less resolved in the following manner: the Social Service Centres (CSS's) and the DSC's, whose complete networks had been established all at once, were temporarily made responsible for front-line social services and community health services in their regions where no CLSC's existed. The objective - much clearer in the case of community health than social services - was that these front-line programs and the resources associated with them would be turned over to CLSC's as they were created in each territory.

Unlike a DSC, a CLSC is a small, autonomous organization with its own board of directors drawn from the community; it does not fall under the authority of any other network establishment. However, the slow development of the CLSC's and the "interim" policy described above has not augured well for the exercise of this autonomy, for three reasons. Firstly, the CLSC's represent a new concept of multidisciplinary care; their orientation and mandate were not well understood and they lacked credibility. Secondly, their efforts to transform DSC programs to meet the particularities of their own mandate and organizational culture, sometimes meet with resistance from the DSC's. Thirdly, due to economic constraints, a large portion of the CLSC network has been built up solely through transfers of programs and resources from the DSC's.

This relatively weak position has been tempered to some extent by the great utility of the CLSC, a utility which is often recognized by the network, if not by the general public nor by some politicians. Despite numerous challenges to their organizational structure, their orientation, their mandate, and their very existence, the CLSC's have ultimately been "protected" by the Ministry for 1) their relatively low cost, 2) their community-level intervention, their closeness to the people; and 3) their flexibility. Together, these assets ensure that the CLSC's can be called upon to fulfill a wide variety of specific mandates, as various "social problems" gain priority within government.

The CLSC's earliest involvement in occupational health and safety was of an ad hoc nature, a response by certain establishments to the particular needs of their communities. About fifteen CLSC's were running some sort of occupational health program before the 1979 LSST was adopted. Their approach appeared to correspond to the spirit of new law, in the sense that they actively encouraged workers' appropriation ("prise en charge") of their own health and safety. But the CLSC's were barely mentioned in the LSST. Their near-absence was justified by their lack of credibility, and the fact that the network was far from complete at the time. But the more important factor is that, since the LSST gave employers associations and unions authority over occupational health and safety through the board of directors of the CSST, the CLSC's approach to animating workers was considered "inappropriate": they were mistrusted by both sides.

With the passage of the law, little changed for the majority of the CLSC's that had no occupational health and safety program of their own. Then, in 1982, as part of the policy to complete the CLSC network, a new directive (la "Politique cadre") was issued by MAS, imposing the transfer of front-line occupational health services and corresponding resources from the DSC's to the CLSC's. But the position of the CLSC's in occupational health and safety remains precarious. Their participation is still opposed by the board of directors of the CSST, as it had been during the development of the policy. Their contracted relationship with the DSC's creates either real or perceived ambiguities with respect to their autonomy, and with respect to their authority over the physicians that work with their health and safety teams. Most original CLSC programs in occupational health have been abandoned. And it has as yet proven impossible to effect a functional integration of the CSST-financed teams into the CLSC organization.

3.6 The Federation of CLSC's (FCLSC)

We have already described the slow progress made in the establishment of the CLSC network between 1972 and 1982. During these ten years, the future of the CLSC's had never been secure. In 1975, four years after the establishment of the first CLSC, the Ministry of Social Affairs had mandated a six-member team to carry out a detailed evaluation of existing CLSC's, and to make recommendations with respect to the CLSC experiment in general. At this point, although forty CLSC's had obtained charters and initial budgets, only fourteen were considered "viable".[9] In this critical context, the independent CLSC's developed a shared feeling of threat, and the Federation of CLSC's was established to respond to this threat.

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[9] According to the Federation of CLSC's (1977: 22), a CLSC becomes viable when it has filled approximately twenty positions in such a manner as to permit it to carry out its designated functions. That is, the positions would include a variety of professionals and support staff as well as a director and program coordinator.

Like the Québec Hospital Association, the Federation of CLSC's has never had an easy time representing its autonomous constituents through a single voice. In the case of the FCLSC, this difficulty has been compounded by the fact that, unlike the hospitals, the CLSC's were embryonic establishments whose objectives and modes of functioning were still ambiguous and as diverse as their communities, their boards and their directors.

But while the AHQ represented well established institutions with individual budgets of at least $10 to $15 million and as many as 4,000 employees each, the CLSC's could scarcely have been considered "institutionalized" in 1975: they were few in number, and the most established had a budget of under $1 million, with about 60 employees. While objective of the AHQ was to defend the strong position of the hospitals against increasing incursions by the State, the objective of the FCLSC was to fight for the very survival of the CLSC's.

The Federation began as an association of CLSC directors, and was highly mistrusted by a majority of CLSC professionals who were in the process of unionizing during the mid-1970's. Some of the more radical directors were themselves not wholly committed to the FCLSC. In effect, the occupational health and safety dossier played a significant role in defining the FCLSC as an employers' association on the one hand, but as a much-needed representative of the institutional interests of the CLSC's, on the other. It would appear that certain worker/management barriers were broken down as the FCLSC became involved in the occupational health dossier.

In 1977, the Federation called a meeting of CLSC Directors, in which it explained its perception of the importance of impending reforms in occupational health and safety for the future of the CLSC's. Fewer than half the CLSC's sent delegates to the meeting. But a committee of 12 was formed and prepared a brief, entitled Propositions de la Fédération des CLSC concernant la réforme gouvernementale sur la protection de la salubrité, de la sécurité et de la santé dans les milieux de travail. It was presented to Marois in March, 1978, six months before the publication of the White Paper.

The position taken in this document was quite "radical" in the context of the ongoing discourse around the reform. For example, the Federation put forth the argument that, since occupational health concerned the workers first and foremost, workers ought to form a majority on mandatory occupational health and safety committees.[10] This "extreme" strategy of the FCLSC did little to enhance the CLSC's already-suspect reputation among the decision-makers around Pierre Marois. But the attitude of the Federation was that it had little to lose. The CLSC's were bound to be excluded from the new legislation anyway, since neither management nor the unions nor Sauvé of the CAT wanted to see their participation, each for their own reasons.

For the Federation of CLSC's, occupational health was an important dossier for two reasons. Firstly, it was evident that the new policy implied front-line intervention, and one of the only means of survival for the CLSC's was the promotion of a CLSC "monopoly" in (public) front-line health and social services. Secondly, the CLSC network was suffering from restrained growth and repeated budget cuts; the occupational health and safety system was perceived to be one of the only new sources of money for the network. Given the CLSC's poor reputation, the strategy of the Federation was based on a meager objective: to ensure that the CLSC's were at least mentioned in the new law. Given this, they would carve out their own space with time. Thus the

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[10] Only the CSN position was more "radical", in that it was against any legislation in principle.

FCLSC continued to lobby, to make its presence felt in the arena.

With the strong support of Michel Vezina, Lazure's special advisor to Marois, the Federation managed to ensure that the CLSC's were at least mentioned in the LSST (art. 116). This article says that the DSC's may subcontract with a CLSC for the provision of occupational health services. Later, Vezina was to reiterate the CLSC role in a 1980 communique to the network, but neither article 116 nor the MAS communique resulted in any CLSC participation in occupational health policy during the first two years.

The survival of the CLSC's continued to be the primary interest of the FCLSC after the passage of the LSST. Thus, lobbying efforts revolved around establishing the CLSC's as the rightful purveyors of all front-line services, as per the LSSS. In this context, it of course clashed with the interests of both the DSC's and the AHQ, which at that time were united only in their opposition to CLSC involvement in the occupational health dossier. And it met with little further support from the Ministry until 1981, when Mireille Vaillant became director of community services, and a commitment was made to decentralization and the completion of the CLSC network. Then in 1982, with considerable input from the FCLSC, the Politique cadre was published by MAS obliging the DSC's to contract with CLSC's for front-line occupational health services.

Since the publication of the Politique cadre, relations between the FCLSC and the AHQ have intensified. The AHQ has attempted to engage the FCLSC in provincial negotiations around the DSC-CLSC contracts for occupational health services, but the FCLSC, perhaps recognizing its relative weakness in relation to the AHQ, chose to advise its constituents to negotiate individually with the DSC's. More recently, however, the FCLSC has become more aggressive. Recognizing that the CLSC's as a whole are bound by a common document, namely, the CSST-DSC contract, they have joined with the DSC's Provincial Committee to develop a strategy for negotiations with the CSST. But this is seen as a "pragmatic" tactic that has not displaced the ultimate objective of seeing the occupational health dossier integrated into the CLSC as any other community health program.

CHAPTER IV

COMPROMISE: THE ROOTS OF THE OCCUPATIONAL HEALTH AND SAFETY SYSTEM

The development of a comprehensive occupational health and safety policy was one of the first projects on the agenda of the new Parti Québecois government when it came to power in November, 1976. The law that was finally passed in December 1979 reflected - as does all legislation - aspects of the régime's ideological orientation as well as certain political and economic imperatives specific to the times. But the roots of the policy clearly lie in socio-political dynamics that pre-existed the Parti Québecois' rise to power.

In order to fully understand contemporary dynamics surrounding the implementation of the Occupational Health and Safety Act, we must look back, in three directions:

- to the rise of union and media interest in the issues
- to the troubled history of the Workman's Compensation Board (CAT), and

- to the restructuring of the public health system in the early 1970's.

4.1 Political Pressure

In Québec, the FTQ was a major impetus in increasing public and government awareness of the problem of occupational health and safety. In a major brief to the Duplessis government in 1959, it had drawn attention to the steady increase in work accidents, and called for a public enquiry into the administration of the CAT. The following year, miners in Chibougamou called a massive strike over dangerous working conditions. Throughout the 1960's and early '70's, a number of union demands for public enquiries into dangerous working conditions were refused by the CAT. Press coverage of these stories and of a number of major work accidents, such as that at the Turcotte Interchange construction site in 1967, further increased public awareness and political pressure.

At the international level, in the general tide of increasing state intervention and regulation of social problems, the 1970's was the decade in which a number of governments turned to the issue of occupational health. The United States adopted the Occupational Health and Safety Act (OSHA) in 1970, making it one of the first nations to implement a coherent occupational health policy. The foundation of the policy was the development and enforcement of norms and regulations designed to prevent industrial accidents and disease. In 1972, the Robens Report was published in Britain, under a Labour government. It's orientation was towards a "public health" model of occupational health as opposed to the American regulation and inspection model. It recommended the separation of inspection and prevention, and advocated parity participation of unions and management in health and safety committees within every enterprise.

This international activity, in conjunction with increasing public awareness at home, was significant in pushing the Québec Liberal government, elected in 1972, to consider reforms to the province's incoherent occupational health and safety regulations. At the time, numerous mandates were scattered among four ministries and over 20 governmental organizations and private associations. In April 1974, Jean Cournoyer, then Minister of Labour initiated an interministerial committee to look into the dossier. It produced a draft of a general law, the objective of which was to redistribute responsibilities among the Ministry of Environmental Protection, the Ministry of Social Affairs, the Ministry of Labour and Manpower, and the Ministry of Natural Resources. The momentum for reform increased in 1975, amid renewed political pressure surrounding the highly publicized Asbestos Strike. Another major FTQ brief to the Ministry of Labour denounced the CAT, and called for a coherent health and safety policy with a strong focus on prevention. Legislation was immediately passed respecting victims of asbestosis and silicosis[11], and Cournoyer promised major reforms by the end of the year. Although there was some increased activity on the part of the Ministry of Social Affairs in the form of special mandates to the DSC's, no significant occupational health reform was announced.

The Labour Minister renewed his promises early in 1976 - this time referring to new legislation, rather than reforms, which was to be in place by January 1, 1977. It had become evident that, given the state of development of international and national norms in the domain of occupational health and safety, and the irretrievable reputation of the CAT, reforming the current regulations would be insufficient. Investigations of European régimes were undertaken with a view to elaborating an entirely new, comprehensive policy. But in

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[11] "An Act respecting indemnities for victims of asbestosis and silicosis in mines and quarries", adopted in June 1975.

November 1976, the Liberal government lost its mandate and the Parti Québecois came to power.

4.2 The Workman's Compensation Board (CAT)

The Workman's Compensation Board was established in 1928 as an insurance board financed by employers' premiums. While often viewed as a progressive measure for disabled workers, it should be noted that the Act also protected employers, by limiting the possibility of suit for liability. But historically, the Board was under constant criticism for its questionable administration of employers' funds, as well as for its distance from, and insensitivity to the accident victims' plight.

Criticism increased with the post-war shift in public expectations. In 1961, the CAT commissioned an administrative audit, published as the Wood Report; it recommended a number of minor internal reforms in response to increasing criticism and union demands. Little changed, however, and dissatisfaction amongst workers with their treatment by the CAT steadily rose. In 1973, another internal document, the Minault Report, attributed public dissatisfaction with the Board to poorly trained employees, who were insensitive to the work milieux and to the reality and impact of industrial accidents. In other words, a change in attitude was recommended, but no major change in mandate, objectives or structure. By this time, however, both public pressure and an international trend towards preventive policies was gaining momentum.

One year later, in 1974, the Department of Labour's interministerial committee was convened to discuss reforms in occupational health and safety policy. Now, the CAT struck its own task force, under the auspices of Alphonse Riverin, to review its objectives and structures. And in the autumn of that year, it finally created a Department of Prevention.

The Riverin Report was published in July, 1975. It recommended a total reform of the CAT's functions, including the creation of a new Régie, a decentralization of services, and a unification of inspection services. With respect to prevention, the role of the Régie would be limited to the setting and enforcement of regulations and norms, as in the American model. Further support for prevention would come in the form of joint (union and management) sectorial associations and health and safety committees in enterprises. In other words, responsibility for primary and secondary prevention would lie with the private sector.[12]

The Riverin Report was being considered as a possible basis for new legislation by the Minister of Labour in 1976, just before the election which defeated the Liberal government. But the Labour Ministry and the CAT were not the only organizations working on that legislation. The Ministry of Social Affairs was quite active on its own.

4.3 The Public Health System

The development of a "public health" model for occupational health and safety policy in Québec has its immediate origins in the adoption of the Law respecting Health and Social Services (1971). Previous to this, the involvement of health institutions in occupational health and safety had been minimal: hospitals had engaged in contracts with the Workman's Compensation Board for various rehabilitation services, and certain inspection services were provided by municipal public health units. But the 1971 legislation provided a renewed ideological and structural basis for coherent intervention on the part of the Ministry of Social Affairs and the health and social service network.

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[12] Primary prevention is defined as the design and implementation of preventive measures in the work place. Secondary prevention refers to the gathering and production of information and instruments necessary for primary prevention.

The orientation of the Ministry and the new network towards prevention paralleled the development, in parts of Europe and in other Canadian provinces[13], of a "public health" model for occupational health and safety. Public health had curiously been neglected in both the Castonguay-Nepveu Report and in the 1971 legislation, until the creation in 1973 of the Community Health Departments (DSC's). Along with the CLSC's, the DSC's inaugurated a progressive concept of public health in Québec, defined in terms of a "community approach", focusing on prevention and the promotion of health among the most vulnerable population groups through multidisciplinary intervention.[14]

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[13] See Ministre de la Santé nationale et du Bien-etre social, "L'Hygiène du Travail au Canada, Situation Présente", June 1977.

[14] The division of labour between CLSC's and DSC's was along "front-line" and "second-line" services, referring to direct contact with the population in the first case, and research, planning, technical expertise and program evaluation in the second case.

On the basis of earlier, peripheral involvement of the health sector in occupational health and safety, and in view of the network's involvement in prevention and public health, Claude Forget, Minister of Social Affairs was invited to participate in the interministerial committee for health and safety convened in 1974 by the Minister of Labour. As a result of a redistribution of tasks among the four participating government departments, which was the major outcome of that committee, MAS mandated the DSC's "to concern themselves with the new preoccupations and policies of the ministry in matters of industrial medicine, and to intervene in cases of victimized workers or threats of industrial poisoning" (MAS, Annual Report, 1974-75).

Network interventions in occupational health began to increase from that time, in the form of special mandates to the DSC's, and a number of CLSC projects initiated mainly by groups indigenous to the work milieux (company nurses, unions, etc). Encouraged by evolving expertise and will within the DSC's, and statements from the Department of Labour that major reforms were immanent, MAS struck its own task force in 1975. The objective was to develop the elements of an integrated health and safety policy, which would form the basis for new legislation. In a sense, then, MAS was in competition with the Ministry of Labour. Its recommendations constituted a strong counter-proposal to the CAT's Riverin Report, published the same year.

The MAS task force proposed a system that included an official recognition of the role of the expert health professional in prevention. It recommended mandatory joint committees for health and safety within enterprises, with employee contributions to the cost of prevention programs which went beyond the committees' demands. However, employers would be required to contract with health and safety professionals to institute prevention programs, and prevention would fall under the auspices of MAS, independent of the compensation board and of labour politics. To consolidate its role in occupational health MAS named the heads of DSC's "health officers" (_"médecins hygiènistes"_) by virtue of the Act respecting Industrial and Commercial Establishments.

This model - especially the element of separation of prevention and compensation - was vigorously promoted by the new breed of doctors involved in the development of the Departments of Community Health. They were supported by MAS - including the Minister and deputy minister, as well as the lower echelons of the bureaucracy - in their view of occupational health as a public health issue, and one that should not be tied financially to employers' interests.

What we have seen is that interest in occupational health policy was stimulated from three different directions, each with orientations and a heritage of its own. The heritage of political pressure was mainly that of the unions, especially the FTQ, and its orientation was towards a labour-relations model of occupational health. The orientation of the CAT was administrative and bureaucratic, but it had the experience required to run a large financial institution. The public health sector was ambitious with respect to the occupational health dossier. It's professionals were committed to setting up a system based on expertise, and "neutral" with respect to labour relations. Up to the end of 1976, it had the firm support of the Ministry of Social Affairs.

4.4 New Government, Old Constraints: 1976-1979

In November 1976, there was a change of government. As opposition to an incumbent Liberal Party, the Parti Québecois had taken issue with the government over its delays and vacillation with respect to the introduction of occupational health legislation. It had in fact included a promise of power to the workers, or at least the unions, in the matter of occupational health. Therefore, when it replaced the Liberals as the party in power, this dossier was one of the major ones to be distributed amongst the members of the Prime Minister's cabinet.

In 1977, in a meeting of the new ministers who formed the Comité Ministerielle Permanente du Développement Social, responsibility for the development of legislation in occupational health was assigned. Contenders for the job included the Minister of Labour, the Minister of Social Affairs, the Minister of the Environment, and the Minister of Mines and Natural Resources - all heads of Departments that currently held carried some function related to the issue. For a number of months, there was uncertainly as to who would receive the mandate, and members of the lower echelons of MAS and the network who had been intensely involved in planning during the Liberal régime, did not know whom to be lobbying. Finally, Pierre Marois emerged as the Minister responsible for developing a new policy and new legislation in occupational health. Although he was also Minister of Labour at the time, the dossier went to him in his capacity as Minister of State for Social Development. Thus there was ostensibly no predetermination of the Ministry that would ultimately administer the new Act.

There are a number of reasons that the mandate was handed to Pierre Marois. The most significant reason is that this policy was viewed, politically, as an exercise in labour relations: the FTQ had played an important role in the victory of the Parti Québecois, and occupational health and safety was perceived to be a route by which its support could be consolidated. Given this predelication towards a labour-relations model of occupational health, Pierre Marois was perceived as the most qualified minister to handle it. He and Robert Sauvé, whom he appointed to head the CAT in February 1977, both had strong union backgrounds.[15] In contrast Denis Lazure, Minister of Social Affairs, was less familiar with labour-management negotiation, and less well known in that milieu. Further, to place occupational health and safety in the hands of the Department of Social Affairs - regardless of who its minister was - would not be conducive to productive relations with either the CPQ or the unions. They were used to the game rules and the staff of the Ministry of Labour.

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[15] Sauvé had been secretary general of the CSN in the 1960's, while Marois, a labour lawyer, had been director of l'Association co-operative d'économie-familiale.

But Marois did not work in a vacuum. Aside from his cabinet, he had the support of numerous consultants from various other government departments. Lazure, Minister of Social Affairs, appointed Dr. Michel Vezina as his special advisor with respect to the occupational health and safety dossier, to represent the Ministry and its network in their dealings with Marois' team. But Lazure then turned his attention to his own mandates. He had been awarded the opportunity to work on other dossiers of particular interest to him - for example, psychiatry and daycare. He also faced certain "crisis" situations, such as the hospital deficits. In his view, as well as that of his new deputy minister, Claude Deschenes, they were beginning their mandate with a new set of objectives and priorities. This put the highest echelons of the MAS somewhat at odds with the professionals who worked at on the more operative levels, such as Vezina.

4.5 The Public Health Network: from Leadership to Subordination

Vezina found himself isolated within the Ministry, dealing directly with Marois and Sauvé. He did have the strong and active support of a number of individuals within the community health network and the universities, and they lobbied Pierre Marc Johnson, Minister of Labour - who was a doctor himself - and Lazure as well.

But Lazure's interest, in their view, was minimal. The political will and ambition related to this project that had been demonstrated by Forget was now absent.

Ultimately, then, the Department of Social Affairs and the representatives of the public health network were but a minor influence in the elaboration of the White Paper and the law. The major influence on policy formation was the FTQ, especially Emile Boudreau, along with the new leader and professionals at the CAT. The CPQ, though vehemently opposed by Marois, had considerable political influence well. It lobbied other members of the National Assembly who represented its members' constituencies, and who would later vote on the law.

The fact that the policy has a major public health component to it stems less from any particular influence of MAS, than from Marois' own determination to neutralize the traditional role of industrial medicine. He viewed industrial doctors who worked for private companies as unequivocally supportive of management, against the interests of both workers and the government. On this matter, there was a consensus amongst those intimately involved in developing the policy. Against the will of the CPQ, all major corporations and most of the medical profession, occupational health was going to be removed from the hands of private industry and private medicine.

But a split within Marois' cabinet reflected opposing views as to the best mechanism for integrating the public health component into the law. Some members shared the opinion of the community health consultants and insisted that prevention and compensation should not be controlled by the same organization. Their position was that prevention would never be given the attention it required to become effective, in an organization whose main mandate was financial: the collection of premiums and the payment of compensation. Further, if the employer paid for prevention, a clear commitment could not be expected. Another aspect of the argument was that the preventive aspect of the law should be under the control of MAS and its network, which had the particular expertise as well as a general mandate in public health and prevention. Finally, there was concern that a single, massive agency controlling the entire system would become bureaucratized and slow and would not encourage the activity and innovation required in launching a new policy.

Other participants, including representatives of the CAT, strongly resisted any official role for MAS, and defended instead the need for a single, comprehensive organization to ensure the coordination and integration of all aspects of the policy. The objective was to avoid any resemblance to the disjointed, incoherent system that they were replacing. Ideally an occupational health service would be created within the structure of a new Occupational Health and Safety Board, along the lines of the French system. Marois himself favoured this model. He and his cabinet were uneasy over the reputation of the MAS network; it was considered by many to be too independent, "self-important", inefficiently coordinated and somewhat radical.

In the final analysis, it was decided that the CSST would contract directly with the CH-DSC's, rather than with the Department of Social Affairs. It would appear that there was strong pressure to minimize as much as possible the implication of MAS and its network in the policy. Their wide reputation for over-complexity was probably due to the fact that it is the most highly decentralized government department, with lateral ties and mechanisms of complementarity replacing simple hierarchic relations. Indeed, it takes much longer for far-reaching decisions to make their way through such a system, in contrast to, for example, the CSST, where decisions are made at the centre and automatically become directives to the regional bureaux. The public health network was still relatively new, poorly understood and unproven.

The compromise that was struck was determined by political and economic constraints. Aside from administrative concerns mentioned above, there was strong opposition by unions and the employers to placing MAS in control of any aspect of the policy; only the Ministry of Labour would do, where they had long established lobbies and contacts. Economically, however, it was considered neither feasible nor efficient to construct a health system within the CSST, parallel to the one that already existed by virtue of the Law respecting Health and Social Services.

The shape of the final compromise was as follows: authority over all aspects of the policy was given to the CSST, under the auspices of the Department of Labour, but the CSST was compelled to contract with the 32 CH-DSC's for occupational health services.

By keeping ties to the network as limited as possible, that is, by contracting with a specific institution rather than a whole network of institutions, it was hoped that difficulties related to the intersection of two systems would be reduced. The CH-DSC's were then a logical choice. Firstly, the CAT had experience in contracting with hospitals, for example, with respect to certain rehabilitation programs. Secondly, the CLSC's- the only alternative - were highly unattractive: their network was far from completed, they were new and untested, their future was still unknown, they had a history of internal conflict, and they were considered politically radical by employers.

As a result of the lobbying efforts of the Federation of CLSC's and the strong support of Michel Vezina at MAS, the law states that the DSC's _may_ sub-contract with CLSC's for occupational health services. This clause respected the LSSS, which had assigned front-line services to the new CLSC's, but it was the minimum recognition possible of the fact that the DSC's were just one element of an integrated network.

Following eight months of heated debate in the National Assembly, Bill 17 was tabled on June 20, 1979. During the fall of 1979, sixty-nine briefs were presented to the _Commission permanente du travail et de la main-d'oeuvre_, covering official and unofficial positions of unions, corporations, employers' associations, doctors' associations, the AHQ, the Federation of CLSC's, groups of professionals, groups of industrial accident victims and so on. Minor adjustments were made in the wake of masses of contradictory recommendations coming out of these briefs. Meanwhile, MAS prepared to fulfill its future mandate by allocating thirty-six new positions in occupational health to the DSC's. Eventually these would be financed by the CSST.

The Law was finally adopted on December 21, 1979[16], despite solid opposition from Liberal members of the National Assembly. They considered it disrespectful of employers' rights and of the private domain in general.

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[16] See Appendix "B", excerpts from the Act Respecting Occupational Health and Safety (R.S.Q. S-2.1).

CHAPTER V

CONTENTION AND DEFENSIVENESS:

A BRIEF HISTORY OF THE SYSTEM FROM THE ADOPTION OF THE LAW TO THE PRESENT

With the passage of the LSST, the public health sector and the CSST had to begin living the compromises that had been made. In the following pages, a cursory outline of events will suggest that, amid conflicts, negotiations, and realignments, a *modus vivendi* has not easily been worked out. In the final analysis, the friction *between* the CSST and the network, has emphasized friction *within* the network.

5.1 Year One

The passage of the LSST did not unleash a sudden flurry of activity within the health network. We will remember that the DSC's already had certain specific occupational health mandates and a minimum number of occupational health professionals, and they had begun to inventory the industries in their regions even before Bill 17 was adopted. Much of the preparatory work before intervention in the workplace would actually begin, had to be carried out at the decision-making levels of the CSST.

For the CSST, this first year was devoted to putting in place the administrative structures related to it's mandate. The decision was made to implement regulations pertaining to prevention on a sectorial basis, with priority groups of industries defined in terms of the industries' relative accident rate, according to CAT records. There had been alternative courses of action which were rejected at the time, for example, to organize around the most serious or the most common health risks. But it seems likely that the final decision was guided at least in part by the FTQ contingent on the Administrative Council, and by Robert Sauvé's own perceptions and objectives with respect to the role that occupational health might play in the sectorization of the union movement. This orientation set the context for the future functioning of the health sector in the work milieux. It was an approach inherently incompatible with the public health network, which was organized to intervene on a territorial rather than sectorial basis, and to build its expertise in terms of health problems rather than a particular milieux.

The definition of Priority Group I and the regulation pertaining to sector-based associations were amongst the earliest regulations adopted by the CSST. In 1982 it passed the regulation regarding prevention programs to be drawn up by employers (indicating measures to be taken, with timetables). But regulations affecting the internal organization of the workplace around prevention, i.e. the setting up of occupational health and safety committees within work establishments, waited a number of years.

Table I indicates the extent of preparedness of the work milieux six years after the implementation of the Act: aside from prevention programs filled out somewhat arbitrarily by employers, there was still little of the expected organization within the workplace. This was to have an important effect on the functioning of the health network when direct intervention began in 1982.

In 1980, immediately following the adoption of the Act, MAS distributed a notice to the DSC Directors (Circular 1980-31) regarding the implications of the Occupational Health and Safety Act for the functioning of the network. It discussed the mechanisms by which the Standard and specific contracts with the CSST would be drawn up, and outlined the relation between the CSST and the network as per the LSST. The most significant element, however, was the general guide provided in this

TABLE I

Établissements de 21 travailleurs ou plus des groupes I et II ayant mis en place des mécanismes de prévention (1985)

	Programme de prevention initial	Comite de sante et de securite	Representant a la prevention
Groupe I			
* Bâtiment et travaux publics	359 (53 %)	9 (1 %)	1 (0.1 %)
* Industrie chimique	133 (86 %)	48 (31 %)	25 (16 %)
Forêt et scieries	323 (79 %)	172 (42 %)	62 (15 %)
* Mines, carrières et puits de pétrole	98 (82 %)	61 (51 %)	39 (33 %)
* Fabrication de produits en métal	357 (87 %)	155 (38 %)	54 (17 %)
Ensemble du groupe	1 2[illegible] (72 %)	445 (25 %)	181 (10 %)
Groupe II			
Industrie du bois (sans scierie)	157 (82 %)	65 (34 %)	23 (12 %)
* Industrie du caoutchouc et des produits en matière plastique	134 (74 %)	59 (33 %)	24 (13 %)
* Fabrication d'équipement de transport	82 (73 %)	46 (41 %)	23 (20 %)
Première transformation des métaux	70 (91 %)	56 (73 %)	34 (44 %)
Fabrication des produits minéraux non métalliques	93 (83 %)	56 (50 %)	30 (27 %)
Ensemble du groupe	536 (80 %)	282 (42 %)	134 (20 %)

Source: CSST, Direction Réseau, Fichier des données de base de prévention (1985-12-31), Fichiers régionaux (1985-12-31).

* Secteurs où il existe une Association Sectorielle paritaire.

circular for the distribution of roles and responsibilities within the network.

Referring to both the LSST and the Law respecting Health and Social Services (LSSS), the circular specified that front-line services in the workplace were to be provided by CLSC's, whereever they existed. The role of the DSC's was described as regional co-ordination, the examination and administration of medical personnel, data collection, epidemiological studies, and evaluation. MAS's role was defined as more "formal" than instrumental. It included observer's status on the board of directors of the CSST, approval of certain documents, such as the Standard CSST-DSC Contract, and responsibility for assuring the quality of occupational health personnel.

5.2 The Standard Contract

In that first year, under the auspices of Jean-Louis Bertrand, Vice-president of Prevention at the

CSST[17], the Standard Contract between the CSST and the CH-DSC's was drawn up. As stipulated in article 107(2) of the LSST, a draft of the Standard Contract was submitted to MAS for approval, beginning a series of negotiations with respect to its content. It was at about this time that the CSST suggested the creation of a Joint Standing Committee including representatives of MAS and the CSST, to provide a forum for discussing matters of mutual interest. There were disagreements, however, over the format of this committee. The CSST did not envision the participation of network representatives. Therefore, representing MAS in the negotiation process were Vezina, now head of Occupational and Environmental Health Services, the Assistant Deputy Minister, and the Director of Financial Services. The head of the treasury board also played a role. In the end, the Ministry managed to change several administrative clauses concerning financing, job guarantees and training.

The Québec Hospital Association (AHQ) had been liberally consulted by the CSST during the elaboration of the Standard Contract, given that it sat as a voting member on the board of directors of the CSST at the time, as a representative for the CPQ. Thus, the liaison between the AHQ and the CSST was strong. Both were interested in maintaining a tight relationship between hospitals and the CSST, with as little interference as possible from MAS. But the MAS Circular 80-31, discussed above, had already introduced the suggestion of a different set of "game rules" than those envisioned by the CSST and the AHQ: it had forewarned them of the probability of the decentralization of health services to the CLSC's. It was not the first warning, either; article 116 of LSST also recognized this possibility. But it was one which the AHQ and the CSST preferred not to encourage, each for their own reasons. The AHQ wanted the hospitals to retain control of occupational health services - and their (approximate) 30 million dollar budget. The CSST, for its part, retained all of its original administrative and political reservations about the CLSC's, and the Ministry's ability to co-ordinate its network.

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[17] Bertrand had arrived at the CSST in 1979, after serving as Lazure's head of cabinet in the Department of Social Affairs.

The content of the Standard Contract was quite abstract, revolving around the nature of the relationship between the CSST and the CH-DSC. It's purpose was to define the minimum conditions to be included in future specific contracts. It interprets the role accorded the DSC's in the Act, including their right to sub-contract with CLSC's. Reference is made to the rights of the CRSSS with respect to regional co-ordination, reflecting the recognition of their role in the LSST, but going no further than the LSST in specifying that role. The Ministry itself is not mentioned.

Ostensibly, the role of MAS in occupational health policy is not connected to the role of the DSC's. In this respect, the Standard Contract does not contradict the letter of MAS's 1980-31 circular to its network. But to understand the implications of MAS's absence from the Contract, we should recognize that, as with the LSST itself, there was a clear indication that the Ministry was not invited to play the role of intermediary between the CSST and the hospitals having a DSC.

The Standard Contract, then, effectively cut MAS off from its network, in so far as occupational health and safety was concerned. It made the CH-DSC accountable to the CSST for all network responsibilities in the domain. The AHQ, as the CH's representative, became the network's representative. To avoid any conflict of interest, it withdrew from the CPQ and from the administrative council of the CSST.

5.3 The First Specific Contract

During 1981, the board of directors of the CSST finalized the contents of a draft of the first Specific Contract for the CH-DSC's, and presented it to the AHQ. The specific contracts would be signed annually, and would refer to the particular tasks planned for a given year. The Standard Contract provided the general guidelines for the specific contracts, which would ultimately be signed between a DSC and a regional office of the CSST. The first specific contract arranged for the establishment of base teams in each of the DSC's. These base teams had a minimum of five members: a coordinator, a researcher, an industrial hygienist, a consulting physician and clerical support.

The ADDSC would have preferred to negotiate this contract on behalf of the DSC's itself, since relations between the DSC's and the hospital administrations were far from friendly. There were few in the DSC's who felt that the AHQ could or would adequately defend their interests. However, the hospitals were the legal administrative units to which the DSC's belonged, and the AHQ was designated as their representative in matters that affected them as a group. The ADDSC on the other hand, only had the status of a "professional organization", legally representing individuals and not institutions.

The AHQ insisted on its prerogative to negotiate the specific contracts, on the pain of advising the hospital administrators to withhold their signatures.

Ultimately, the contracts were negotiated between the CSST and the AHQ, with insignificant adjustments agreed upon between certain DSC's and the regional bureaux of the CSST. The process was a frustrating one, since the regional bureaux had no autonomy and each time a DSC wished to add a clause, the CSST central had to be consulted by the regional bureau. Some DSC's succeeded in adding a few clauses, for example, regarding specific deadlines, but there was very little room for flexibility. By September 1981, almost all the DSC's had signed.

Interesting though, was what was left out of these contracts. While mechanisms for determining the resources required by each DSC was stipulated, the precise amount of the funding was not. This allowed the CSST full control over the most important zone of uncertainty, namely, how much money would actually be transferred. The precise guidelines for elaborating a health program were also specified outside of the contract, as well as the minimum requirements for health programs.

The DSC's initial responsibilities, according to this first contract, were to create an infrastructure and to develop an organizational plan for intervention in Group I industries. Difficulties abounded: qualified professionals were difficult to recruit, appropriate training was not readily available, and the physical organization of the base teams - simply finding and renting space, setting up offices, etc. - proved more time-consuming than had been anticipated by the CSST when it set it's deadlines. These same problems have plagued the DSC's ever since.

Despite much preparatory work that had been carried out by the DSC's since 1980, including the inventory of industrial establishments in their territories, and the recruitment and training of personnel, coherent intervention in the form of developing specific health programs for establishments awaited the signing of a second contract with the CSST, in 1982. In the mean time, however, MAS had established certain policies of its own with respect to its network, which would affect the organizational mechanisms for such intervention.

5.4 The "Politique Cadre"

In 1981, a decision had been taken by the government to complete the network of CLSC's. The health and social service system was at the same time suffering financial difficulties, and MAS was handling them in part through repeated budget cuts to the CLSC's. The decision to complete the CLSC network therefore depended on two possible strategies: 1) the transfer of resources from other institutions, and 2) new money, from sources other than the MAS budget. The CSST was one obvious source.

Front-line occupational health services had been "assigned" to the CLSC's in 1980 MAS Circular. Since that time, however, very few DSC's had involved the CLSC's in the development of occupational health programs. From the point of view of MAS, it was essential that any new funding from the CSST find its way into the CLSC's. Therefore, a decision was taken at the upper levels of MAS to intervene quickly, before front-line occupational health services became more firmly entrenched in the DSC's.

The result was the publication in August 1982, of a set of guidelines for the network. It outlined the respective roles and responsibilities of the DSC's, CLSC's and CRSSS's with respect to occupational health, and it required contracts to be drawn between the DSC's and CLSC's for the provision of frontline services in occupational health and for the appropriate transfer of resources. This politique cadre took effect just as the CSST had finalized a draft of its second contract with the DSC's. It had the force of a directive.

The second CSST/DSC contract revolved around the recruitment of personnel necessary for developing health programs and instituting health services for Group I industries. According to MAS's politique cadre, a proportion of these resources would go the CLSC's. A few DSC's, who were accustomed to co-operative efforts with the CLSC's on other projects, found no particular difficulty with the politique cadre. A large number of DSC's felt that a dispersion of resources at such an early point in the implementation of the policy, would prevent them from building up strong centres of expertise in occupational health. A small number condemned the politique cadre outright, insisting that the LSST had accorded them the prerogative of coordinating occupational health services on their territory, and that MAS had no right to dictate terms.

This last perception was strongly shared by the AHQ. To the AHQ, the politique cadre was a blatant interference of the civil service in the internal functioning of the hospitals. In the face of the politique cadre, some DSC chiefs and coordinators began to recognize the possible advantages of closer ties to the AHQ. For its part, the AHQ began to appreciate even more the strategic value of the DSC's in its general contest with MAS. Between the frustrating experience of contract negotiations, and the politique cadre, a gradual rapprochement between the AHQ and the DSC's became more likely.

5.5 The Transfer of Resources to the CLSC's

By the end of 1982, most DSC's had signed contracts with CSST regional bureaux initiating the production of health programs for Group I industries. These contracts determined the form and content of the health programs, in terms of "minimum requirements", and stipulated a deadline of one year for the completion of Group I. They also stipulated the number of professionals and technicians to be recruited to produce these programs, on the basis of ratios of health professionals to workers. Depending on the number of Group I workers in any given community, the number of CLSC-bound resources was as high as three or four positions, or as low as half a position or none at all.

But the transfer of resources to the CLSC's was not addressed in the CSST/DSC contract. Rather it was an issue to be resolved through the organizational plans which each DSC was to draw up, according to the politique cadre. Despite the hesitation of many DSC's, all but five were ready with their organizational plans within six months of the publication of the politique cadre - that is, by the beginning of 1983. Most were ratified by the CRSSS, where necessary, within one or two months.

This step was followed by the negotiation of service contracts between DSC's and CLSC's. This process was more erratic. The contracts referred to the functional integration of DSC and CLSC responsibilities, and thus to the relationship that would be established between them.

A small number of DSC/CLSC contracts were signed before or immediately following approval of the organizational plans. The others took between three months and a year to be negotiated. Almost all DSC's had signed service contracts with CLSC's by the summer of 1983. This was one year after the publication of the politique cadre, and an average of eight months after the signing of the DSC/CSST contract for Group I industries.

This does not mean, however, that no health programs were being produced during the negotiation period. In some cases, resources were transferred and CLSC's went to work despite the lack of agreement on specific clauses of a contract. In other cases - and in regions where the network of CLSC's was incomplete - the DSC's had begun producing health programs themselves, as soon as the personnel became available. But the production of health programs was considerably slower than the CSST had hoped for.

5.6 The CSST and the DSC's: Relations Deteriorate

The uneasy integration of the CLSC's into the picture was not the only source of strain and delay. One of the most serious problems faced by the DSC's and

CLSC's was the recruitment of qualified personnel. Recruiting doctors posed a particular problem for the DSC's, due to a high rate of turnover. This was often blamed on the overly bureaucratic and restrictive nature of the doctors' jobs under CSST policy.

The deadlines set for the production of health programs was a source of strain. All professionals found that the timetable set by the CSST was unrealistic, given the lack of preparedness of the work milieux (e.g. no health and safety committees). For the CSST, however, the appearance of productivity was essential to maintaining the support of its board of directors. Thus pressure was put on the DSC's to perform, and that performance was measured against a quota of health programs to be produced within a given time period.

The CSST was not entirely satisfied with the results it was obtaining from the DSC's. The argument was that a number of DSC's were far too slow in producing health programs, and a few had produced none at all by 1984. In the CSST's estimation, production was most efficient where it remained in the hands of the DSC's. Indeed, many DSC's agreed that it was difficult to obtain cooperation from some CLSC's.

Towards the end of 1984, the CSST cut off funding to four DSC's who had reported no health programs at all completed by CLSC's in their regions. It requested MAS to place these DSC's under trusteeship. Rather than follow the CSST recommendation, MAS took a more informal route to diffuse the problem, and the delinquent CLSC's started to report on their progress. However, this threat from the CSST had the effect of forcing the institutions of the public health network to take a more assertive stand in support of their positions.

In an effort to manage the many facets of the occupational health and safety dossier, a Provincial Committee for Occupational Health and Safety had been established by the DSC's, in affiliation with the ADDSC. As it struggled with professional and administrative problems, it's lack of direct access to the CSST became a greater and greater liability. The Provincial Committee was one of those elements of the DSC system that came to favour an affiliation with AHQ. Such an affiliation would give it greater weight in its relation with the CSST and with the CLSC's as well.

If the CSST appeared to be overpowering in relation to the public health network, it was not on very strong ground in a more global context. The economic crisis and the development of public sympathy with the private sectors had put Sauvé on the defensive. The CPQ and other employer groups became more aggressive in its criticism of the CSST and demanded changes in the law. The cry was taken up by the press and the opposition in the National Assembly. In 1983, the Liberals called for the firing of Sauvé, citing gaps in service, delays, errors and malaise at the level of the board of directors. Bill 42, an Act Respecting Work Accidents and Professional Diseases, was tabled in November 1983, and sparked the longest, most vociferous and bitter debate the National Assembly had known. A new version was deposited in June, 1984, with greatly reduced powers for the CSST. In this context, the CSST was determined to demonstrate that it had its responsibilities under tight control.

5.7 The DSC's and the AHQ: Relations Improve

Pressure continued to rise in 1985. Sauvé's contract as director of the CSST was renewed for a two year period, but in a brief to Frechette, Minister of Labour, the Québec Chamber of Commerce proposed the abolition of the CSST on the basis of its bureaucratic inefficiency, suggesting in its place a totally privatized régime. The CSST's accounting procedures were the object of a prolonged controversy in the National Assembly and the press, as the real size of it's debt was questioned. And the CSST came under attack from Québec's ombudsman for its handling of individual cases.

In face of this constant pressure in other areas of its mandate, it became more and more important for the CSST to maintain the appearance of providing services to workers for the premiums it collected from employers. It's demand for impressive figures on the number of workers reached by the health network and the number of health programs produced, was reinforced by its need to justify its expenditures on prevention to the board of directors. The threat of trusteeship for the DSC's was a powerful CSST weapon: it was a threat to the Director of the DSC personally, aside from the institution. Though the CSST may not have expected it to be imposed, it was a demonstration of intent. What the CSST could and did do in some cases was withhold resources.

In response to the CSST's tough stand with unproductive DSC's, the DSC's Provincial Committee collaborated with the AHQ in publishing the Bilan et Perspectives en santé et sécurité au travail (1985). This document was a detailed accounting of the activities, achievements, and especially the difficulties encountered by the DSC's since the adoption of the LSST. It was at once a defense of the DSC's ability to manage the dossier, and a censure of the CSST's and MAS's apparent distance from the reality of their situation. This collaboration affirmed the growing affiliation between the DSC's Provincial Committee and the AHQ. In a formalization of this affiliation, the Provincial Committee gained an official position in the structure of the AHQ, and the AHQ gained the expertise and loyalty of the DSC's in its negotiations with the CSST. But in joining forces with the AHQ, the DSC's now share in that organization's interests, including its antipathy to MSSS intervention in the affairs of the network.

5.8 The CLSC's and MSSS: In Defence of a "Community Approach"

For their part, the CLSC's recognized that, while some DSC's may have shared their interests, the AHQ did not. They would have to develop support and legitimacy for their new position in occupational health through their own strategies. The FCLSC lobbied MAS and found a sympathetic ear in Occupational and Environmental Health Services. Funding was obtained for a DSC-CHUL project entitled: L'Approche communautaire et la santé au travail dans le réseau des affaires sociales. As a result of the discourse raised during the preparation of this document, a colloquium was organized in May, 1985, on the community approach in occupational health. DSC members were somewhat reticent to participate, since the position of their Provincial Committee was that the "community health approach" was better not talked about when one's credibility was on the line with the CSST. Therefore, the colloquium turned out to be mainly a CLSC affair - but with several significant developments.

Pierre Marois was a keynote speaker. He strongly defended the role of the public health network in occupational health, and declared the LSST to be a "public health" law. He insisted on "la prise en charge par le milieu de travail" as a primary objective of the law, thus supporting the "community approach" as the CLSC's defined it. Another speaker was Jacques Lamonde, assistant deputy minister for health. He pledged support for the development of occupational health as a community health program, in what appeared to be a reversal of the long-time marginality of MAS in this dossier. It was hoped, following the colloquium, that the document Projet d'un cadre de référence pour une approche communautaire en santé au travail, would be endorsed by MAS, thus consolidating the CLSC's role in the dossier.

After several months of silence following the Colloquium, there was a flurry of activity at MAS - called the Ministry of Health and Social Services (MSSS) from 1986. A new Director for Prevention and Health Promotion was recruited from the network; several new positions were allocated to Occupational and Environmental Health Services; a Provincial Coordinating Committee was set up to try to develop a common network strategy in negotiations with the CSST; two advisory committees were struck, bringing together members of the network, to formulate recommendations with respect to changes in the LSST and the Standard Contract of 1980. As well, there was a tentative effort to find acceptance for a document entitled Cadre de Référence pour une approche communautaire en santé au travail. This, however, was effectively blocked by the DSC's Provincial Committee/AHQ. Ultimately, the Co-ordinating Committee also crumbled due to lack of support by the DSC's Provincial Committee.

5.9 The Current Situation

In December of 1985, a Liberal government returned power. It immediately struck three task forces to study privatization, deregulation, and the rationalization of government agencies, thus defining the parameters of a new socio-political debate. The situation with respect to occupational health and safety, always rife with uncertainty, became highly volatile. Sauvé was replaced by Monique Jérome-Forget as director of the CSST, and she halted the development of health services for Group III industries while she studied the current situation. Decisions are about to be made that may greatly affect the involvement of the public health network in occupational health.

The network does not face this threat united. On the contrary, the CLSC's are pitted against the DSC's, the DSC's Provincial Committee/AHQ is pitted against MSSS. Health Programs are finally being produced (see Table II), but the extent to which this is an indication that the public health network is doing its job is still being debated. The DSC's appear to have accepted to play by the CSST's game rules, in return for a certain amount of influence via the AHQ. It is, perhaps, a strategy of attempting to influence those rules "from within".

The CLSC's, however, are far less committed to the future of the system as it stands. Calling attention to another set of rules, those laid out in the LSSS, the

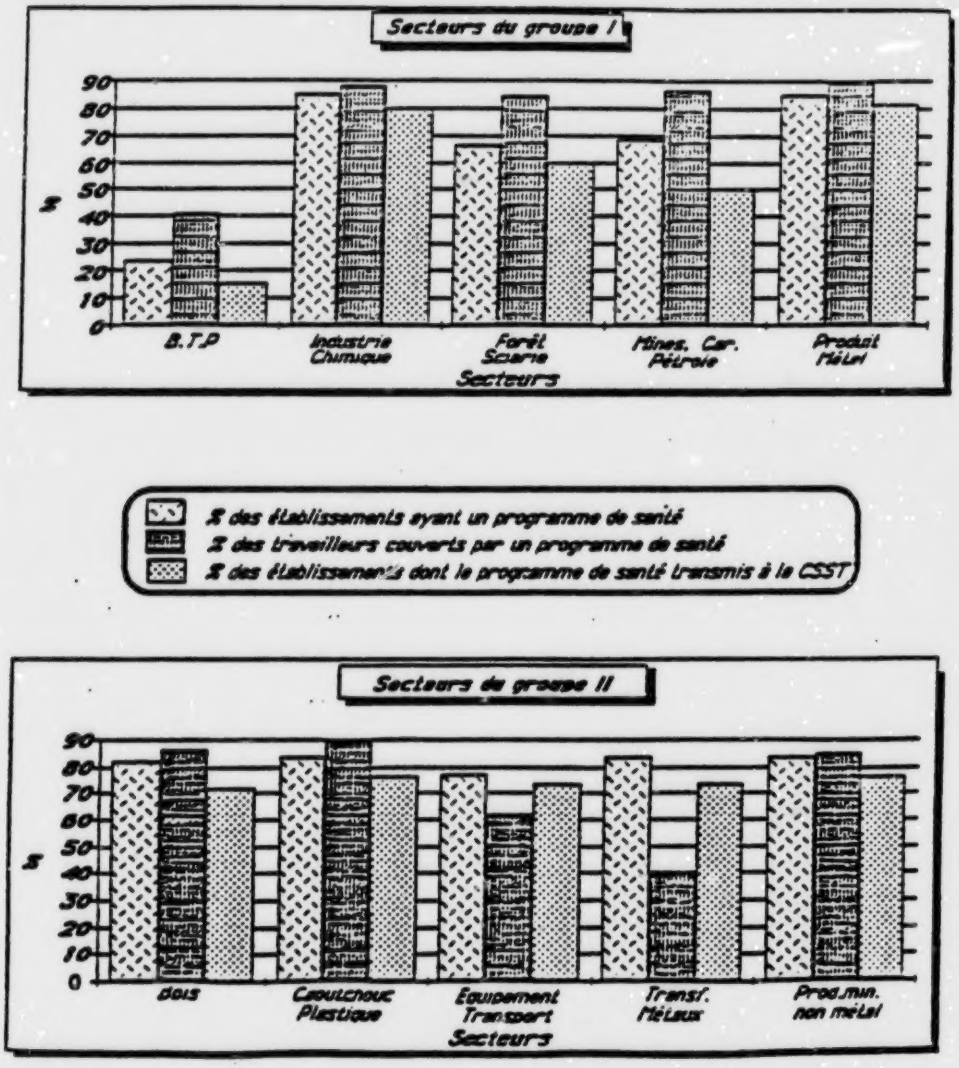
CLSC's and the Ministry appear to have little confidence that occupational health under the CSST will ever be oriented towards community health, in which the network's role would be to encourage and support the development of new social norms regarding health and safety in the workplace. As we shall see in the following chapters, these ideological differences are the expression and the result of social dynamics which have shaped the system over its first six years.

TABLE II

LE RESEAU:

Pourcentage de réalisation pour les secteurs des groupes I et II

(Toutes catégories d'établissements)
1985



Ministère de la santé et des services sociaux
Services de la santé au travail

CHAPTER VI

DECENTRALIZATION: THE IMPLEMENTATION PROCESS AND ITS OUTCOME

6.1 Abstract

In this chapter, the implementation of the MAS decentralization policy for front-line occupational health services is examined in greater detail. The services in question include the elaboration and application of Specific Health Programs for industries which fall into Priority Group I.[18] The elements of the health programs are determined by provisions in the LSST (art. 113) and by regulations and guidelines adopted by the CSST.

There were three steps to the implementation of the decentralization policy:

1. The elaboration and circulation of the politique cadre (published in Aug. 1982).

2. The elaboration and submission of organizational plans by the DSC's, outlining the distribution of occupational health resources

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[18] The other priority groups had not yet been defined at the outset of this policy. It currently applies to Priority Group II, as well.

between health sector establishments in their territory (Oct. 1982 - Dec. 1983).

3. The negotiation and signing of specific contracts between the DSC's and CLSC's in each DSC territory, for the provision of front-line occupational health services (Feb. 1982 - Jan. 1984).

The key actors in the process and their formal roles were:

CSST: elaboration of DSC contracts.

MAS: elaboration of the politique cadre.

DSC's: development of organizational plans, signing of contracts with the CSST for health services for Group I industries, and signing of contracts with CLSC's for the provision of front-line services.

CRSSS: approval of organizational plans where there was no transfer of front-line services to a CLSC.

CLSC's: negotiation and signing of contracts with DSC's.

AHQ: negotiation of DSC contracts with the CSST and the FCLSC.

FCLSC: negotiation of DSC-CLSC contracts with the AHQ.

6.2 The Decision to Decentralize

During or just prior to the 1981 Provincial election, a decision had been taken by the government to complete the CLSC network, and to consolidate and decentralize all front-line public health and social services. This was a "political" decision, that is, it had been taken at the level of the elected representatives, including the Premier and the members of the interministerial committee. The policy statement - entitled _Le Réseau des CLSC au Québec: un parachèvement qui s'impose_ was published on April 3, 1981. In the same month, the Parti Québecois was reelected to head the government.

The decision to adopt a policy of decentralization had a history that is significant for understanding the particular issues around the case of occupational health. The policy was consistent with the intentions of the Health and Social Service Act (LSSS) of 1971. That reform sought to reorient the health system towards prevention, and towards multidisciplinary and continuous services, in order to take pressure off the highly technological and costly field of medical treatment. It had not been entirely successful on that account, due to dynamics and developments that are beyond the scope of this report. But the 1981 decentralization decision was a reaffirmation of those global, long-term financial considerations.

Right after the election, the CLSC's were subjected to budget cuts which were to be repeated during the next few years. No new MAS funding was available for the promised development of new CLSC's. It would have to take place on the basis of either a) resources transferred from existing establishments within the network, i.e., hospitals and social service centres, or b) resources from sources outside of MAS and its network. In the case of occupational health, both of these alternatives were available in one source. The DSC's were "temporarily" in charge of front-line services in the work milieux, the resources for which came not from the Ministry, but from the CSST. The decentralization of these services from the DSC's to the CLSC's would add to the "repertoire" of CLSC programs. New money to develop the occupational health programs would then continue to flow into the CLSC's from the CSST on an annual basis.

The success of the decentralization policy was important to the Ministry for several reasons, all revolving around the management of ever-rising health care costs. MAS funds were becoming more and more concentrated in the hospitals, and with the introduction of global budgets, this meant that hospital decision-makers were gaining more and more control over government spending. There was little faith on the part of the Ministry that these decision-makers considered more than their own institution's and clients' interests. The decentralization of resources was to promote the development of an alternative - and more economical - form of health service. It was to divert a certain number of resources to multidisciplinary prevention programs at the community level, before leaving the rest to the high-tech treatment industry. For the Ministry, the central issue was whether it would be successful at decentralization in the face of powerful resistance from hospitals, i.e. the AHQ.

In the case of occupational health, the budget in question was an ever-growing one: each year, a new group of industries was to be added to those already receiving health services, with new resources awarded accordingly by the CSST. Since the signing of the first CSST/CH-DSC contract, this money had been paid by the CSST as a protected budget to designated hospitals, for the fulfillment of their DSC's' contracted responsibilities in occupational health. The hospital administrators were unwilling to share whatever control they maintained over this revenue. The heads of their DSC's, on the other hand, were unwilling to share the special status and responsibilities accorded them in the Occupational Health and Safety Act. They had gained considerable power and prestige through this dossier since 1975, when they had been named medical officers (médecins hygiénistes). The occupational health mandate had been their's almost since the inception of the DSC's, and it was not a dossier they would easily share.

For the CLSC's, the commitment to complete the network was only the first victory in a long struggle for survival. The condition of that victory - that is, the compromise involved for other establishments - was inauspicious. The type of relations they could expect with other establishments in the network, the extent of their autonomy, the limits of their responsibility and their degree of acceptance in the professional community would be defined during the process of implementing the policy. Given the constraints and stakes, it is not surprising that the implementation of the decentralization policy engendered a climate of defensiveness amongst the establishments of the health and social service network, over both resources and roles.

6.3 The "Politique Cadre" for Occupational Health

Because of the CSST connection, the decentralization of occupational health services was handled quite separately from the transfer of other DSC resources to the CLSC's. On the one hand, the Ministry was in a rush to implement this particular transfer before the next CSST/CH-DSC contract would be signed, arranging the funding for Group I industries. But there was also some concern on the part of the CSST that occupational health was to be used as an "experimental case". Of course, the CSST could not "oppose" the MAS decentralization policy. But it was agreed that any transfer of responsibilities in the realm of occupational health would be carried out according to specific, well-defined official guidelines, with the force of a government directive, thus diminishing the chance of disruptive chaos. These guidelines became known as the politique cadre. Yet in keeping with the LSST, the CSST would continue to consider the CH-DSC's ultimately responsible for occupational health services, and would not deal with the rest of the network.

A first draft of the politique cadre was completed by April, 1982, one year after MAS' announcement of its commitment to decentralization. It was entitled: Projet de politique cadre d'administration des services de santé au travail, and it was circulated within the network along with a series of annexes. The annexes included the MAS Circular 1980-31, establishing that the role of the CLSC's had been foreseen at the time of the adoption of the LSST, and several guides related to the application of particular articles of the LSST. They were to have included, as well, a model DSC-CLSC contract, and the MAS training policy. These last two items, however, were à venir.

The Ministry was "geared up" for the promotion of the CLSC's. As a result, the Projet de politique cadre favoured the CLSC's adopting a large degree of autonomy and responsibility for front-line occupational health services. For example the doctor in charge of a workplace (the médecin responsable) was to be administratively and professionally attached to the CLSC of the territory in which the establishment was located (proposal, art. 6.6), and the DSC's would have to consult with the CLSC's regarding the criteria for the certification of these doctors (proposal, art. 4.4). The CLSC's would participate in the preparation of an evaluation instrument (proposal, art. 4.7), and in decisions regarding the deployment of resources in a DSC territory (proposal, art. 4.2). An enhanced role for the CRSSS was also favoured in the Projet de politique cadre. Their participation and approval was required for the sub-regional organizational plans (proposal, art. 11.1, 11.2), and they were to play an active role in assuring that occupational health services were integrated with regional health and social service planning (proposal, art. 11.3, 11.6).

Once the Projet de politique cadre had been circulated by MAS throughout the network, one of the authors, a professional working with Michel Vezina at MAS, organized a team of consultants from the various institutions of the network to hear their responses and concerns. Participating in the consultation were representatives of the Federation of CLSC's and the Conférence des CRSSS. The AHQ declined at first to send a representative, on the grounds that it was opposed to the politique cadre in principle; MAS was seen to be intruding on the authority of the hospitals to manage their own contract with the CSST. But a delegate from the CH-DSC's did participate, and the influence of the AHQ "behind the scenes" was strongly felt. Also of importance in contributing to the rewriting of the politique cadre were several members of Deputy Minister Claude Deschênes' staff, as well as Directors Fortin (Health) and Vaillant (Community Services), who approved the final version.

In August, 1982, four months after the distribution of the proposal, the Politique cadre d'administration des services de santé au travail de première ligne was published. This final version was far more "lean" than the earlier one, only 13 pages as opposed to 25, and only a single annex: the circular 1980 -31. The model DSC-CLSC contract promised in the first draft was never drawn up by MAS; it was rather left to the parties involved. Edited out entirely was a section on the responsibilities of MAS, the argument being that these responsibilities are derived from authority higher than the politique cadre. The major role of the CRSSS was shortened to include approbation of an organizational plan only if establishments other than CLSC's were used to provide front-line services (politique cadre, art. 9.1).

As for the CLSC's, there were significant limitations to the status that had been envisioned for them in the April proposal. In general, many aspects of the relations between the DSC's and CLSC's that had been specified in April, were now left to be negotiated by the establishments themselves in the context of the DSC-CLSC service contracts. Only the "functional" integration of the doctor in charge of a workplace was mentioned, but not defined (politique cadre, art. 3.5); there was silence with respect to the doctor's "administrative" and "professional" integration (politique cadre, art. 5.4). The DSC's retained full control over the organizational plans, with the exception, of course, of the requirement that they contract with CLSC's where these existed.

There was an obvious effort in the final version of the politique cadre to refer to the Health and Social Service Act of 1971 for legitimation, rather than the Occupational Health and Safety Act. But the LSST was a very real constraint that could not be ignored. It was the most powerful resource of those parties who opposed the politique cadre, and wished to ensure that the DSC's retained their authority in spite of decentralization. The LSST served to limit the extent to which MAS could intervene in the definition of DSC responsibilities in occupational health, since a premise of the LSST was that the hospitals were autonomous institutions with which the CSST could contract directly.

The contract model was the preferred model for inter-establishment relations in the upper echelons of the Ministry. It appeared to respect the autonomy of both hospitals and CLSC's, while imposing a context of negotiation and "equitable" relations. But many of those who were closer to the field had only to look at the example of DSC-CSST relations, which were inequitable despite their contractual regulation, to recognize its inadequacy. The contract then was not a solution to inequity, but seemed to enshrine it in writing.

The Ministry's reliance on the CH-DSC's and CLSC's to co-ordinate their own relations was intended to make the politique cadre a flexible guide, with room for the parties to manoeuvre. But this was interpreted, by some, as negligence and inaction. The network waited for further news from MAS, in the form of training programs or guidance with respect to the orientation of occupational health within the public health system, but the Ministry ended its responsibility with the publication of the politique cadre. This was an administrative directive which met current objectives for the system, and was not really concerned with occupational health per se.

6.4 The Organizational Plans

The politique cadre was circulating in the network as the CSST/CH-DSC contracts for Group I industries were being signed. Both of these documents impinged on the development of organizational plans for the DSC territories. The process of drawing up the specific plans for each region was fairly described by Dr. Louis Drouin, president of the DSC's Provincial Committee, in a later document:

> L'élaboration d'un plan d'organization a nécéssité plusieurs discussions entre les CLSC, CRSSS, CH-DSC et la CSST. Le CH-DSC se devait de connaitre au préalable les ressources à être affectées à chaque éventuel point de service ou CLSC. Il doit formuler, à cet effet, plusieurs hypothèses d'organization, qui sont analysées par la suite, avec les différents intervenants. Il est évident que si un plan d'organization prévoit confier les services de santé à un ou deux des CLSC d'un territoire, le CH-DSC a du négocier au préalable avec chacun d'eux et faire accepter ce principe par le CRSSS et la Commission dans certains cas. Pour les régions éloignées, le problème se posait defféremment en ce sens que pour rejoindre les populations de travailleurs, le CH-DSC devait prévoir de nombreux points de services, donc, un fractionnement très grand du nombre de ressources qui lui étaient allouées.
>
> AHQ et DSC, 1985: 11

The situation was one of enormous uncertainty: a number of institutions, each one with a new and untested mandate, were trying to co-ordinate their "complementary" roles under constraints of time and money beyond their control, all the while maintaining the objectives of fulfilling their responsibilities as they perceived them, and guarding their autonomy vis à vis each other. The DSC's had a contract with the CSST, for which they would remain responsible. Their concern was how to fulfill this responsibility given the constraints and uncertainty created by the politique cadre. The organizational plan would be their first attempt to bend the new rules to their own advantage.

How was the game played? We know from the dates on which organizational plans were deposited with the CRSSS, that the length of time that the process took was highly variable from DSC to DSC (See Table III). Since the politique cadre imposed the signing of sub-contracts with CLSC's where they existed, there were fewer uncertainties in the 18 territories where the CLSC network was complete. Still, in these cases, the DSC's usually wanted to use the organizational plans to determine not only the disposition of resources, but the principles of the relation between the DSC and the CLSC's as well. For example, they stipulated timetables for the transference of resources, control mechanisms and accountability as they themselves were subject to in their contracts with the CSST.

The variability in the time required to finalize the organizational plans was often a function of individual approach on the part of the parties concerned. For example, in some cases a history of harmonious relations between a DSC and the CLSC's existed, and the organizational plans were negotiated in a climate of cooperation. In other cases, relations were tense in general due to personal incompatibilities, and this was reflected in a complete lack of communication with the CLSC's in the development of the organizational plan. Individual attitudes, however, do not explain everything.

TABLE III

HISTORIQUE DE L'ORGANISATION DE LA SANTE AU TRAVAIL DANS LE RESEAU

TERRITOIRE DE CH-DSC	Date signature contrat 81	Date signature contrat 82	Date signature contrat 83	Date dépôt 1er plan d'organisation (83)	Date approbation 1er plan CRSSS (1983)	Date signature 1er contrat CLSC - DSC							
						1	2	3	4	5	6	7	8
Région													
01 Rimouski	25-05-81	19-10-82	22-11-83	N/D	N/D	02-83	02-83	02-83	02-83	02-83			
Gaspé	08-06-81	28-03-83	13-10-83	17-12-82	14-01-83	09-83	09-83	09-83	09-83	09-83	09-83	07-83	
02 Chicoutimi	N/D	10-82	06-83	N/D	06-83	10-83							
Roberval	04-81	05-82	05-83	05-83	N/D	06-83	06-83	06-83	06-83				
03 C.H.U.L.	N/D	-01-83	-09-83	-10-82	-05-83	09-83	09-83	09-83					
St-Sacrement	-05-81	21-12-82	15-11-83	15-02-83	12-05-83	07-83							
Montmagny	1982	1983	1984	1982	1983	1983	1983	1983	1984				
Lévis	21-05-81	17-12-82	-12-83	-03-83	23-06-83	06-84							
Enfant-Jésus	01-06-81	09-03-83	07-03-83	28-03-83	15-05-83	—	—	—					
Beauceville	06-81	12-82	16-12-84	22-12-82	02-83	08-83	05-83	06-83	06-83				
Rivière du Loup	25-05-81	20-12-82	04-08-83	09-02-83	08-04-83	07-83	08-83	07-83	07-83				
04 Mauricie	01-06-81	02-12-82	20-09-83	15-11-82	fin-11-82	07-83							
Drummondville	27-04-81	22-12-82	12-01-84	04-01-83	04-02-83								
Trois-Rivières	05-11-81	01-02-83	05-12-83	07-02-83	26-04-83	04-84							
05 C.H.U.S.	16-06-81	19-10-82	23-08-83	30-11-83	14-12-83	03-83	03-83	03-83	03-83				
06A Lakeshore	22-06-81	06-10-82	27-01-84	01-11-82	22-12-82								
Verdun	21-07-81	21-12-82	15-12-83	-01-83	-02-83	09-83							
Mais.-Rosemont	04-09-81	10-11-82	16-02-84	02-12-82	02-12-82	11-82	04-83	03-83					
Ste-Justine	21-05-81	19-10-82	02-12-83	04-02-83	09-03-83	06-83							

TABLE III (cont'd)

HISTORIQUE DE L'ORGANISATION DE LA SANTE AU TRAVAIL DANS LE RESEAU

TERRITOIRE DE CH-DSC	Date signature contrat 81	Date signature contrat 82	Date signature contrat 83	Date dépôt 1er plan d'organisation (83)	Date approbation 1er plan CRSSS (1983)	Date signature 1er contrat CLSC - DSC							
						1	2	3	4	5	6	7	8
Région													
06A Général de Montréal	-09-81	-07-82	-10-83	-09-82	-02-83	12-82							
Sacré-Coeur	28-07-81	29-09-82	25-08-83	08-11-82	22-12-82	12-82							
Cité de la Santé	07-04-81	02-11-82.	06-12-83	-06-82	-12-82	01-83	03-83						
St-Luc	-05-81	28-10-82		-11-82	22-12-82	06-83	06-83						
06B Lanaudière	29-05-81	09-12-82	08-11-83	12-01-83	13-12-83	01-84	01-84	01-84					
St-Jérôme	05-06-81	22-12-82	02-11-83	01-04-83	12-04-83	08-83	08-83	08-83	08-83				
06C Honoré-Mercier	25-05-81	27-10-82	16-11-83	-10-82	-12-82	07-83	07-84						
Charles-Lemoyne	25-05-81	16-12-82	18-11-83	26-11-82	07-12-82	09-83	07-83	07-83	07-83	09-83	07-83		
Valleyfield	06-04-81	16-12-82	23-11-83	N/D	N/D	06-83	02-84	04-84					
Haut-Richelieu	N/D	09-11-82	25-11-83	N/D	N/D	08-83	08-83	08-83	08-83				
07 Outaouais (Hull)	27-05-81	22-12-82	21-09-83	N/D	N/D	08-83	08-83	08-83	08-83	08-83	08-83	08-83	
08 Rouyn-Noranda	25-05-81	23-12-82	29-09-83	13-01-83	13-01-83	04-83	03-83	04-83	03-83	03-83	03-83	06-83	06-83
09 Baie-Comeau	N/D	N/D	N/D	N/D	N/D								

AHQ, Bilan et Perspectives, 1985

Certain patterns, while not universal, may still be discerned. For example, where the CLSC's were fairly new and underdeveloped, they were usually willing to abide by a DSC's suggested transfer timetable. On the other hand, where a CLSC thought itself sufficiently developed to handle its mandate, it would challenge a DSC's resistance to immediate transfers. Likewise, in a CLSC with experience in occupational health - and several CLSC's had even more experience than the DSC's - there were strong objections to the controls and authority relations that some organizational plans implied. And complications arose in certain cases where the CLSC network was incomplete. Here, the CRSSS were mandated to ensure that if no CLSC existed, a neighbouring CLSC would assume its responsibilities on an interim basis, or, a service point would be temporarily created in a hospital. However, rather than deal with the transfer process several times over, these DSC's would sometimes insist on continuing to deliver front-line services themselves until such time as new CLSC's were created. Some DSC's refused to decentralize resources altogether, citing the ratio of resources to the size of the territory as prohibitive.

Organizational plans were deposited with the respective CRSSS between June 1982 and April 1983. The variability in terms of the negotiating time was then repeated, to some extent, for the approbation of those plans. In cases where the CLSC network in a given DSC territory was complete, the CRSSS sent the plans on the Ministry, with or without recommendations, in the 60-day time limit stipulated by the politique cadre. In other cases, however, where CRSSS approbation of the distribution of resources was required, it sometimes took longer to analyze and influence the situation. In one case, 11 months elapsed between the deposit of the plan and its approbation, though others took anywhere from three to seven months.

The likelihood of a CRSSS to intervene either formally or informally in the development of an organizational plan was often a function of the relative power of the CRSSS and the hospitals in its region. The CRSSS of Montreal or Québec had no real power to challenge the will of a large hospital; the most they could do was make use of delaying tactics, if for example, a CLSC indicated that the organizational plan was completely unacceptable to them. But in regions where the hospitals were smaller and less powerful, the CRSSS could exert some influence to encourage cooperation and flexibility on the part of the DSC's and CLSC's.

With only five exceptions, all the organizational plans had been approved by the beginning of 1983; that is, over a period of five or six months, most DSC's had negotiated and signed contracts with the CSST, they had developed organizational plans taking into account the politique cadre, and these organizational plans had been approved, where necessary, by the CRSSS. The CH-DSC's have argued that this delay was a significant one, and one beyond their control, brought on by the introduction of the politique cadre. On the other hand, there were more than political problems - or problems related to power - that prevented Group I services from being initiated immediately upon the signing of the CSST/CH--DSC contracts, in the fall of 1982. The procurement and organization of physical and material resources, and especially the recruitment and training of personnel could only have begun once the particulars of the CSST contract were known. Each of these problems contributed to the delays.

6.5 The DSC-CLSC Contracts

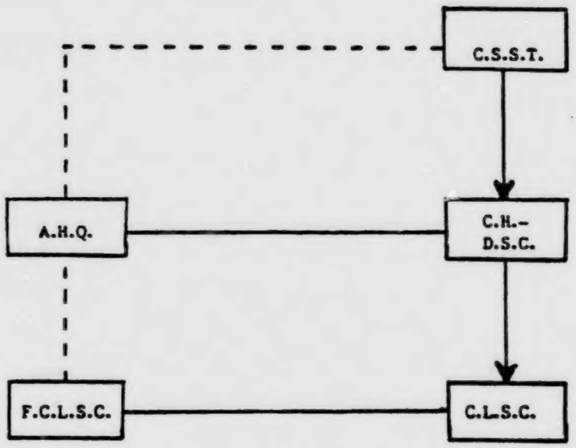
The object of the organizational plans was to define the mechanisms - by territory - for the distribution of CSST resources among DSC's and CLSC's. The contract, on the other hand, was to define the relation between establishments: their respective roles, responsibilities and functions, and what they could expect from each other. The DSC's had attempted to define some of these elements in the organizational plans. But the more significant instrument was to be the contract, and the AHQ - once again representing of one of the signatories of this contract - had set its strategy in motion at the earliest possible moment.

The Projet de politique cadre had been distributed throughout the network in April, 1982. But the intentions of the Ministry had been made clear a year earlier, and certain informal consultations had taken place in the interim. As soon as it was known that a contractual relationship between DSC's and CLSC's was to be imposed, the AHQ began to develop a model contract along the lines of the contract defining CSST/CH-DSC relations. By March, 1982 - a month before the circulation of the Projet de politique cadre - it had delivered a proposal for this model contract to the FCLSC.

It should be noted that the AHQ had refused to respond "officially" to the Projet de politique cadre. The timely delivery of this model contract to the FCLSC, then, ought to be interpreted as the AHQ's "unofficial" response, a strategy for influencing the consultation process without actually participating.

In the mean time, the FCLSC had been working on a similar project. The contractual relation was not a CLSC ideal. Negotiations with the hospitals would test the CLSC's autonomy to the limit. Although they were, on the whole, interested in the occupational health dossier - they knew that the CSST was the only source of new money - they had wished that the CSST budget would be distributed throughout the network by the Ministry or the CRSSS. The Projet de politique cadre had indicated that the budget would remain in the hands of the hospitals, and the CLSC's knew that they would find themselves in the same weak position relative to the DSC's, as the DSC's were relative to the CSST.

The FCLSC had their contract proposal, then, and the AHQ had their's. Throughout the spring and summer of 1982, that is, before the final version of the politique cadre was published, they attempted to negotiate. The AHQ arguments revolved primarily around the provisions of the LSST and the constraints of the CSST/CH-DSC contracts. The FCLSC had no ground to gain on those terms. It rather stood fast on the CLSC's autonomy and monopoly over front-line services, as per the LSSS (1971) and current MAS policy. After several meetings, it became evident that no consensus could be reached through negotiations at that level. The FCLSC withdrew from negotiating, and waited for the final version of the politique cadre.



contract and negotiating relations

On September 16, 1982 - the exact date that the politique cadre came into force - the AHQ distributed it's version of a model contract to the DSC's, to serve as a basis for their negotiations with the CLSC's. Likewise, the FCLSC distributed its version of a model contract to the CLSC's. Negotiations took place at the sub-regional and local level. Their success depended to a large extent, of course, on the particular individuals and establishments involved. If strong CLSC's tended to challenge the DSC's acquired position, it was also true that relatively weak DSC's, in terms of expertise and experience in occupational health, tended to be defensive and to rely more heavily on authority structures than co-operation and consensus. For the CLSC's, the suggestion of a hierarchical relation was out of the question. They were already the weaker of the two parties, and their structural autonomy was their major resource in relations with other institutions. For the DSC's, on the other hand, it was incomprehensible that they could retain ultimate responsibility for occupational health services, without retaining any control over the production of those services.

The pivot of these negotiations became the disposition of the physician in charge of a workplace (the _médecin responsable_). The _politique cadre_, we will remember, had finally left the question of the physician's administrative and professional attachment open. From the point of view of the DSC's, the LSST was clear on the issue: the physician, with the head of the DSC, is ultimately responsible for implementing health programs (LSST, art. 122). Nothing is mentioned in the LSST about professional and administrative association, but one interpretation of the law is that the Act supports the physician's continued attachment to the DSC. This was important to the DSC's, since it provided one of the only means for them to maintain a certain control over the production of health programs by CLSC teams. The

CLSC's, on the other hand, argued that if the production of health programs was the responsibility of CLSC teams, then the physician should be professionally and administratively associated with the CLSC. They were no more tolerant of a DSC physician coordinating their occupational health teams, than the hospitals were of the Ministry's attempts to co-ordinate the functioning of the DSC's.

A number of other issues proved difficult to resolve, as well. Some of these revolved around various commitments that the DSC's had made to the CSST in their contracts, and that the CLSC's were unwilling to absorb. For example, the CLSC's objected to the ratio of health professionals to workers, to the minimum requirements of the health programs, to the unsynchronized fiscal year, to the lack of a position for coordinator where the occupational health team had fewer than 12 members, and so on. Other objections were directed at the DSC's themselves, for example, much of the information the CLSC's were required to collect from the client-workers would be useful only for DSC research purposes, not for improving intervention.

But many of the "irritants" identified by the CLSC's were in fact shared by the DSC's. We might ask, then, why the CLSC's presented a stronger challenge to the DSC's over these issues, than the DSC's had presented to the CSST. The most likely answer is that the DSC's did not negotiate with the CSST; the AHQ did their negotiating for them. The significance of this situation will be discussed further in the following chapter.

The CRSSS had no formal role or means of influence in the negotiation of the DSC-CLSC contracts, as they did in certain organizational plans. In a few situations, informal mediation took place in the context of CRSSS tables de concertation, but the role of the CRSSS during the whole of the negotiations of 1982-83, was generally assessed as "benign".

A few DSC-CLSC contracts were signed within weeks of the approbation of the organizational plans, in the fall of 1982. These were cases in which DSC's had worked well with the CLSC's on other projects, and they were open to the provisions of the politique cadre. With respect to the question of the physician, for example, there was no serious attempt on either side to use it as a lever for either control or autonomy. The vast majority of contracts, however, were not signed before the spring of 1983. During the summer of 1983, the DSC's were already signing new contracts with the CSST for the introduction of health services in Group II industries. In some cases, then, CLSC intervention in Group I and Group II industries began almost simultaneously.

6.6 The Outcome: Integration of Occupational Health Teams in the CLSC's

The transfer of resources and the signing of contracts did not necessarily mean that the integration of occupational health teams in the CLSC's was successfully completed. On the contrary. While the organizational plans and contracts were the major steps prescribed for the implementation of the Ministry's decentralization policy, they represented no more than a coming-to-terms with the implications of that policy. The negotiation process was an education process, each party learning about the other's objectives, resources and strategies, and learning to play by the rules set out in the *politique cadre*. But the "success" of the decentralization policy and the politique cadre in particular could only be assessed by the extent to which occupational health was ultimately integrated into the CLSC organizations.

Some of the difficulties of integration were predictable. The CLSC's had their own form of internal organization, their own mode of intervention, their own organizational culture in accordance with their roots and with their mission under the LSSS. That a marriage between the CLSC's and the more legalistic, bureaucratic CAT-CSST would be a difficult one, was recognized even before the LSST was adopted. For this reason, the CLSC's barely found their way into the law. If there had ever been a thought that the CLSC's and DSC's might ally themselves against the CSST in view of certain shared perspectives vis à vis community health, the intervention of the AHQ as primary interlocutor between the network and the CSST tipped the balance against such an alliance. As we will see in the following chapters, shared interests of the AHQ and the DSC's grew, driving a wedge into the interests that the DSC's and CLSC's might have shared.

For the majority of CLSC's, complaints with respect to the integration of occupational health teams were mainly of an administrative nature, reflecting the compromising of their autonomy by the DSC. Conflicting fiscal years and the demand for reports and statistics created paper work that was both more voluminous and time-consuming than that required for any other program. The co-ordination of the occupational health team was ambiguous, given both a "physician in charge" attached to the DSC, and a CLSC program coordinator. The extent to which the content of intervention was controlled by CSST norms, put the occupational health program completely at odds with any other activity of the CLSC. The CLSC's began to demand that occupational health be treated the same as any other CLSC program. The organizational structures of these establishments were not developed enough to manage both their regular constellation of programs, plus a program with "special status", strict deadlines, and extensive bureaucratic requirements.

Another set of difficulties revolved around the question of "who was at the service of whom": was the role of the CLSC to execute front line services for the DSC, or was the role of the DSC to provide support services for the CLSC? The issue was more than academic. The CLSC's often depended upon the DSC for the development of tools or instruments for intervention. They found that the DSC's would sometimes take months to prepare a "scientifically validated" instrument, by which time their own professionals had put together a workable instrument that served the needs of the milieu. On the other hand, there was a reluctance to provide the DSC's with the information required to carry out the epidemiological and evaluative research which was a major aspect of the DSC mandate. The lack of time due to strict deadlines and insufficient staff, and the imposition on the workers who would not directly benefit, were cited as reasons for refusing to collect this type of data. Finally, there were complaints that the DSC training programs were not preparing professionals for working in a CLSC. After anywhere from three weeks to six months at the DSC, workers would join the CLSC team with certain technical information of limited value in the field, and still requiring training in methods of intervention in the work milieu. This whole set of issues reflected the feeling of the CLSC's that they were involved in a power struggle with the DSC's.

A completely different set of problems existed where the CLSC's had developed their own occupational health program before the adoption of the LSST. About 15 CLSC's originally fell into this category. A number of those dropped their own programs once the CSST-financed teams were transferred - against the counsel of the FCLSC - in order to free their resources for other programs. But some CLSC's, those with the strongest occupational health programs, chose to keep two teams functioning. One known as the "DSC team", provided services only in priority industries, following the norms and schedule of the DSC-CLSC contract. The other "CLSC team" intervened in any enterprise where workers or employers had approached them with particular problems. They would develop tools for animation of the work milieux and for preventive health instruction. In some cases, they would provide information and support for the victims of work accidents. The problem in these CLSC's was defined in terms of the integration of the two teams.

The position promoted by the FCLSC in this matter was that the two teams should be integrated through the CLSC program coordinator. Since CSST funds could not be used in non-priority industries, nor for the types of activities carried out by the CLSC teams, integration could be accomplished through complementarity: a "DSC team" would communicate the needs of a worker population to the "CLSC team", when those needs could not be answered in the context of the CSST program. The two teams would be working together, though not performing the same activities. This ideal, however, has never been achieved. Rather, the usual situation is that "DSC teams" and "CLSC teams" working out of the same CLSC rarely communicate with each other. CLSC team members regard the DSC-trained workers as "strangers" in the CLSC, who do not share in the organizational culture. And "DSC team" members feel that they get more support from the DSC's than the CLSC. The two face none of the same problems in the field, due to their different tasks, and have a certain antipathy towards each other.

Despite the signing of contracts, then, and the relatively smooth transfer of resources, it would be difficult to say that the outcome of the decentralization policy with respect to occupational health and safety was the successful integration of the program into the CLSC's. Rather, it was the catalyst for a whole new set of dynamics between the DSC's and CLSC's, which tended to obscure any shared ideals or complementary functions the two might have. For example, pressure on the DSC's was mounting from the direction of both the CLSC's and the CSST. A change of strategy was clearly needed on their part if they were not to lose effective control of the dossier altogether. The strategy that they developed to defend their position in turn threatened the CLSC's, who turned to MAS for help. These dynamics are described in the following chapters.

CHAPTER VII

THE RAPPROCHEMENT OF THE DSC'S AND THE AHQ: A SOLUTION FOR MULTIPLE PROBLEMS

7.1 Abstract

The object of this chapter is to explain the circumstances which encouraged a significant development within the network, i.e., the official integration of all DSC-related provincial committees and associations into the AHQ. The key elements leading up to this rapprochement were:

- The ambiguous status of the DSC's in the hospitals, and especially the ambiguity of the provincial structures which represented the DSC's.

- The mediation of the AHQ in the negotiation of CSST-DSC contracts, and its weakness in this role.

- The effects of the politique cadre on the stability of the DSC position in the occupational health system.

- CSST threats to the autonomy of the DSC's (e.g. a request to MAS that certain DSC's be placed under trusteeship).

The result of the alliance was a consolidation of the role of the DSC's Provincial Committee/AHQ as mediator between the network and the CSST, and coordinator of the network in the occupational health dossier.

7.2 The Starting Point: DSC Antipathy to the AHQ

Our discussion of the Ministry's decentralization policy in the case of occupational health and safety focused on the implementation process and its outcome. We ended that discussion by indicating that the results of the process were quite problematic in themselves - not only for the CLSC's, but for the DSC's as well. Firstly, the negotiation process had taken place during a good portion of the time allotted them by the CSST for producing the health programs for Group I industries. Then, once contracts had been signed with the CLSC's, the latter's recalcitrance with respect to the technocratic aspects of the program reflected badly on the DSC's, who were directly responsible to the CSST. Squeezed between the demands of the CLSC's on the one hand, and those of the CSST on the other, the DSC's had, in some senses, the smallest margin of autonomy.

The strategy ultimately followed by the DSC's - though not unanimously - was the development of an alliance with the AHQ; that is, they formally authorized the AHQ to act as their representative in dealing with outside parties. The AHQ had claimed this status since 1974, when the DSC's were first established in 32 hospital centres. But without the acquiescence of the DSC's themselves, its authority had never been reliable. It was imposed on the basis of the DSC's being "ordinary" hospital departments, a status which was organizationally ambiguous, and often challenged by their special mandates. In officially delegating authority to the AHQ to act on their behalf, the DSC's gained a powerful ally in their relations with both the CLSC's and the CSST. The AHQ, in turn, gained control over a zone of uncertainty that had previously hampered its own relations with the CSST, and with the Ministry of Health and Social Services.

This alliance may appear to have been an obvious choice, from the mutual benefits named above, but there are several reasons why it bears closer analysis. First, the DSC's traditionally had no affinity with the hospitals in which they were located. Though in the hospitals, they were not of the hospitals. The community health doctors belonged to - in fact, they were at the vanguard of - a very different professional culture than that shared by the majority of professionals working within the hospital. Their "clientele" was the population at large or groups of people, rather than the individual; their orientation was toward prevention rather than treatment; and their focus was on what was happening outside the walls of the hospital rather than inside. Their initial objective had been to preserve these differences, by maintaining their autonomy vis-à-vis the hospital administration.

Second, in the occupational health dossier in particular, there was a history of contention between the heads of the DSC's and the AHQ over who was the legitimate and official "voice" of the DSC's. The community health doctors wished to exert their autonomy in this dossier above all others. Their ideological position was one of "scientific neutrality"; ostensibly, they served the interests of health alone, without regard for the status of the beneficiary. They saw the AHQ as an employers' association, a member of the CPQ, and therefore representing an interest that contradicted their own, one that put efficient production before prevention. Given these conditions in the initial years of the policy, the current alliance between the two represents a significant development within the health and social service network.

7.3 The Provincial Organization of the DSC's

The autonomous establishments of the health network are all represented by their respective associations: the Québec Hospital Association (AHQ), the Federation of CLSC's (FCLSC), the Conférence des CRSSS, and so on. In this context, the DSC's are not autonomous establishments, but hospital departments. Therefore, there is no association representing them *per se*. Rather, the association to which they are officially connected is and always has been the AHQ, which represents the hospitals of which the DSC's are part.

There was always a certain structural tension between the DSC heads and the hospital directors. In order to maintain the "integrity" of community health within a traditional medical establishment - in other words, in order to assert their autonomy - the heads of the DSC's considered it in their interests to distance themselves as much as possible from the authority of the hospital administrators and their association. They had a special status within the hospital, in the sense that they did not fall under the authority of the Director of Professional Services, as other department heads did; the DSC's were administrative departments, as well as clinical. Further, they benefited directly from special government mandates, such as those in occupational health. And they had been awarded certain sub-regional responsibilities, for example, over the emergency departments of all those hospitals in their territory. From one perspective, this regional dimension assured the DSC wider powers than an independent hospital administration enjoyed. Rather than submit to being represented by an association for which they had no affinity, the heads of the DSC's formed their own association, the ADDSC.

The ADDSC was not the equivalent of the AHQ. It could not represent the DSC's as establishments. Legally, it was a voluntary professional association of doctors who were heads of departments of community health, and on that basis shared certain professional interests. But at the time that the DSC's were created, they hardly consisted of more than their "heads", most of whom had been transferred from municipal public health units. The teams were very small, where they were developed at all, and the members of the ADDSC clearly perceived their association to represent the interests of the DSC's as "establishments". For its part, the Ministry tended to address the ADDSC directly when it wanted to communicate with the DSC's in general; less often it went through the hospitals, and never through the AHQ.

At about the same time, at the request of those hospitals having a DSC, the AHQ had established a Community Health Division, attached to its executive committee. This Division grouped together the administrators of these designated hospitals, with some representation from the heads of the DSC's. Its development during the early years paralleled that of the ADDSC. But the ADDSC was a constant irritant to the AHQ. It represented an assumption of autonomy with respect to the hospitals and a threat to the authority of the administrators. When a crisis eventually erupted around the issues of autonomy and conflicting representation, it was over the occupational health dossier.

The ADDSC had prepared a brief for the parliamentary hearings on Bill 17 (proposal for the LSST) in 1978. There followed a confrontation with the AHQ, in which that association insisted on its sole right to represent the DSC's at those hearings, a right delegated by the hospitals' boards of directors, that is, the "bosses" of the DSC's. The author of the brief for the

ADDSC withdrew from the dossier rather than make certain modifications in its orientation required by the AHQ. A new version was eventually written up by a DSC head who was also a member of the executive of the AHQ's Community Health Division. The original ADDSC brief had focused on the role of "scientific neutrality" and the participation of the work milieux in occupational health, while the second version focused more on problems of co-ordination and organization. It was submitted jointly by the AHQ and the ADDSC. Finally a small group of professionals working within the DSC's submitted a second, independent brief, which was closer in orientation to the original ADDSC version than the final AHQ-ADDSC product.

This experience of the "heavy hand" of the AHQ only served to heighten the DSC's determination to remain as independent as possible from the AHQ. The LSST had provided for a significant expansion of the DSC's in terms of personnel. By April 1981, a Provincial Health and Safety Committee (here-after called the DSC's "Provincial Committee") was established, in association with the ADDSC, and consisting of representatives of the health and safety coordinators within the DSC's. More and more, the ADDSC seemed to be representing the institutional interests of the DSC's rather than the professional interests of the department heads. But it was never recognized in this capacity by the AHQ, nor by the CSST.

There were several reasons for this. The AHQ was an employers' association, had been a member of the CPQ and had sat as a voting member of the board of directors of the CSST - though it had given up its CPQ membership and therefore its seat on the board due to "conflict of interest" in the domain of occupational health. But there was a history of relations which assured the CSST that the AHQ "spoke its language" and understood the issues at stake for the CSST. Besides, the AHQ had served as mediator when the old CAT had signed contracts with hospitals regarding rehabilitation. The LSST had stipulated that the contracts be signed with the CH-DSC's rather than the Ministry for precisely these reasons. But this left the ADDSC, a mere "professional organization", voiceless; and the DSC's Provincial Committee, an ambiguous sub-structure of the ADDSC, was unrecognized outside of the network.

7.4 A Redefinition of the Situation

From 1981 through to the end of 1983, the situation with respect to organizational structures remained about the same. The DSC's were totally preoccupied - on an individual basis - with the development of organizational plans and the signing of contracts with the CSST and the CLSC's. The AHQ, as we have seen, assumed its place as negotiating body for the DSC's wherever possible - not only with the CSST, but with the FCLSC as well - but was not always very effective. With respect to the CSST, it had no expertise in public health or occupational health, on the basis of which it could confront some of the CSST's authoritarian provisions. And due to its poor relationship with the DSC's, it could not guarantee their performance. With respect to the FCLSC, we have already seen, the AHQ had failed in its bid to impose its own model contract.

The first three years following the adoption of the LSST were a period during which the "rules of the game" were being discovered and defined. It was during this period, from 1980 through to 1983, that all parties were learning how they fit into the system, and what their margins of autonomy were. It was only towards the end of the first three years that some new structures began to develop, with the potential of responding more appropriately to the positions and objectives of each of the actors.

The CSST was not exempt from all this uncertainty. In fact, the CSST was perhaps the most plagued by uncertainty, since it was ultimately answerable for the entire system, yet had been forced to accept the compromise of dealing with - and depending upon - the unfamiliar and mistrusted public health sector. Rather than risk negotiating, the CSST would present its requirements and conditions to the AHQ and would display no flexibility.

For the AHQ, this relationship was problematic. It had few resources with which to counter the dogmatically legalistic positions taken by the CSST. It could ensure that the contracts did not impose on the autonomy of the hospital or the authority of the hospital administration, but in terms of content issues, it was not in a very good position to mobilize whatever expertise and experience existed in the DSC's. The DSC's were disappointed in the conditions of the contracts negotiated by the AHQ, which did little to enhance the AHQ's image within their ranks. The feeling in the DSC's was that the AHQ did not know the dossier, and did not share the interests of the DSC's, and therefore could not be expected to negotiate a satisfactory contract. But the individual DSC's were relegated to dealing with the regional bureaux of the CSST, while all decisions were made at the centre.

The CSST contracts of 1981 and 1982 contained a number of dispositions that were unacceptable to the DSC's. For example, they objected to the deadlines, the ratio of professionals to workers, the minimum requirements set for health programs, the lack of flexibility in the budgets, and so on. In all these cases, their argument was that the CSST's norms and expectations were unrealistic, and an insult to the professional autonomy of the doctors in charge.

Indeed, from the beginning, the withdrawal of doctors and other professionals from the field of occupational health had been a serious problem. Most of the doctors that had been hired by the CSST from the DSC's between 1978 and 1981 had left, citing their lack of influence on the orientations of the CSST in prevention. But doctors were withdrawing in the health sector, as well. One study (CPMQ, 1986) showed a drop of almost 15% in the number of doctors practicing occupational health full time between 1981 and 1984. The problem was attributed to the lack of professional autonomy and the high level of bureaucratic content involved in working to the terms of the CSST contract.

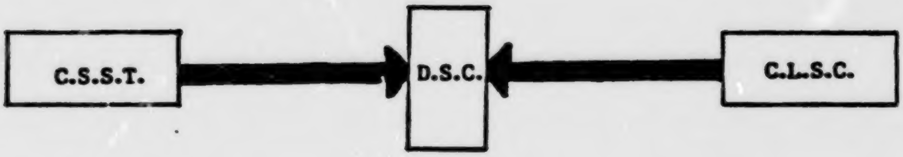
But the source of the DSC's problems was not confined to their relationship - or lack of relationship - with the CSST. From 1982, they had the politique cadre to contend with as well. Two sets of rules, one applied by the CSST, the other applied by the Ministry, converged on the DSC's, and in many ways conflicted with each other. For example, the deadlines set by the CSST for the production of health programs were meaningless in the context of the politique cadre, which called for the approbation of organizational plans, the transfer of resources, the negotiation of contracts with CLSC's, the ratification of "physical plant" decisions by the CRSSS and so on, before intervention could actually begin. Likewise, awarding responsibility for the production of health programs to the CLSC's was meaningless in the context of the CSST contract, which continued to hold the DSC's responsible, and precluded the practice of "community health" as the CLSC's knew it. It seemed impossible to adhere to the letter - let alone the spirit - of both sets of rules simultaneously.

The DSC's were committed to their occupational health mandate as per the LSST, more than they were to the Ministry's decentralization policy. The LSST privileged the DSC's over other network institutions and even over the Ministry, and the DSC's would not have willingly jeopardized that status. The Ministry was perceived as having "sabotaged" their occupational health mandate, by requiring the dispersion of incomplete and insufficiently trained teams, and by divesting the DSC's of control over a sizable budget, as well as the "means of production". The DSC's, then, unanimously condemned the politique cadre.

Even those DSC's which were prepared to decentralize opposed the coercion implied by the politique cadre and in this, they had the full support of the AHQ. The AHQ had strongly contested the legitimacy of the Ministerial intervention in view of the autonomy of network institutions and the provisions of the LSST. It attempted to influence the outcome of decentralization by "selling" its model contract to the FCLSC even before the politique cadre had been published. But as with the CSST negotiations, the AHQ could not "deliver". It had every reason to build on whatever common interest it did share with DSC's, and opposition to the politique cadre was an important one.

From 1983, the experience of working with the CLSC's exposed the full extent of the DSC's vulnerability to opposing sets of rules. The majority of CLSC's were uncomfortable with the contracts that they had finally signed, and responded by "working to rule" - the "rules" being those of the politique cadre. In some cases the CLSC's instituted an administrative boycott, that is, they would do their job but would not fill out the multitude of forms and reports that were required by the DSC. Some CLSC's continued to agitate against all evidence of DSC authority and control, especially in cases where a tendency to authoritative control was most evident.

From the other side, the CSST intensified its demands with respect to the production of health programs, and pressured the DSC's for information from the "field" that the DSC's simply did not have. When the DSC's in turn would request this information from the CLSC's, the latter establishments would sometimes take months to respond. Eventually, in 1984, having received no health programs from at least four DSC's the CSST requested that the Ministry place them under trusteeship. The complaint was looked into informally within the network, with the help of the Ministry and the CRSSS, and eventually the issue was dropped. But the threat was representative of the DSC's dilemma.



the DSC's dilemma

It had been clear since 1978, when the occupational health policy was being developed, that the CSST and the CLSC's did not share the same organizational culture. The CSST's mandate was to administer a law; its orientation was understandably legalistic, and its organization highly centralized. It expected to control conditions in the work milieux through the establishment and monitoring of norms.

The CLSC's, on the other hand, were small but autonomous organizations, whose mandate was to determine and respond to the needs of the community in various health- and social service-related domains. Their intervention in the milieu was multidisciplinary and took the form of education, animation and support. In its effort to juggle these two opposing rationalities, the DSC's were bound to fail. At the same time, they were diverted from their own "scientific" vocation, which in other areas dealt mainly with research, planning and evaluation.

At the end of 1983, then, this was the situation: the DSC's were under pressure from the CSST above, and the CLSC's below. Due to the fact that each of these institutions functioned according to a different set of rules, and different criteria of rationality, the DSC's were helpless to define the situation in a way that a workable strategy for their own participation could be developed. They found little support in the ADDSC, which did not have the resources to respond to this multi--establishment confrontation. The Provincial Committee, associated with the ADDSC, was equally lacking in resources. But the professionals that it represented were becoming impatient with the powerlessness of the ADDSC, and recognized the need to gain some influence with both the CSST and the Ministry in order to manage their occupational health mandate.

7.5 Re-structuration

In the light of the conflicting rules and mounting confrontation with which both the AHQ and the DSC's had to contend, the existing organizational structures which served the two parties were inadequate. Neither was achieving their particular objectives. But for the DSC's, the situation was more urgent, squeezed as they were between the CLSC's and the CSST with no way of mobilizing their essential resource, namely, their expertise. This blockage, this lack of power was keenly felt by the professionals who worked in the DSC's. In the wake of the transfer of resources to the CLSC's and the near-imposition of CSST contracts, they began to agitate for greater participation in the decision-making process. This process had so far been monopolized by the heads of their departments, through the ADDSC.[12]

In December, 1983, during the DSC colloquium where professionals and department heads had gathered, there was a confrontation in which the professionals spelled out their dissatisfaction with the style of leadership of the ADDSC. They questioned the ADDSC's commitment to multidisciplinarity and collegiality, the supposed hallmarks of the new discipline of "community health". Out of this confrontation, under the leadership of a few DSC heads of the "new guard", a new organization took shape, called the Regroupement des DSC du Québec.

The Regroupement was clearly an association of establishments. It's executive included some DSC heads, but mainly professionals who worked within the DSC's, representing the various services such as occupational health. But the creation of the Regroupement did not resolve the specific structural problems of the DSC's. In fact, it created new ones.

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[12] There were more of the "new guard" of community health specialists working as professionals within the DSC's, than heading the DSC's at this point. Many of the department heads were still of the medical contingent transferred from the municipal health units in 1973, or other senior staff who did not have the same training as their subordinates.

For example, the ADDSC had set membership fees at $75.00 per department head, a reasonable amount for 32 individual members. The Regroupement, on the other hand, did not represent individuals but establishments, and it set its fee at $3,000 per DSC. Who was to pay the membership fee? The hospital was responsible for administering all DSC expenses. And from the point of view of the hospital, there already existed an appropriate organization representing the DSC's, namely, the Community Health Division of the AHQ. And the hospitals already paid fees to the AHQ.

During 1984 and '85, there was great confusion regarding the provincial structures which organized and represented the DSC's. Most individuals with whom we spoke either admitted they had no comprehension of what structures existed and what their status was; others offered explanations that conflicted with each other in their details. But during this time, two processes were under way. The first was a re-orientation of the DSC's Provincial Committee for occupational health, and the beginning of its collaboration with the AHQ. The second was the beginning of negotiations between the Regroupement as a whole and the AHQ, with a view to resolving the obvious duplication of delegated rights and authority vis a vis the DSC's.

The DSC's Provincial Committee continued to function during this period, in an ambiguous affiliation with the Regroupement. However, in the autumn of 1984, under the new leadership of Louis Drouin, a broader, more precise and more political mandate was defined for the Committee. According to its organizational plan published in September 1986, this mandate included

> - the exercise of provincial leadership in the co-ordination of resources throughout the health network, with respect to the development and dispersement of scientific expertise in the domain of occupational health
>
> - the exercise of provincial leadership with respect to issues of strategic interest in the domain of occupational health
>
> - the representation of the DSC's in all organizations and committees dealing with occupational health issues.

The first collaboration between the Provincial Committee and the AHQ was the document Le mandat exercé par les centres hospitaliers ayant un département de santé communautaire: Bilan et Perspectives en santé et sécurité au travail. Conducted within the framework of the revised mandate of the Committee, it was of enormous strategic value for both parties. It represented on the one hand, an official response to - or defense against - the CSST's mounting accusations of non-productivity. On the other hand it suggested that both the Ministry and the CSST had not been sufficiently supportive and in fact were responsible for many of the delays. At the same time it promoted the revamped Provincial Committee as the health network's solution to the problems of the previous four years.

This 1985 document was the first of a large number produced by the DSC's Provincial Committee, ranging in subject matter from technical guides for various types of industries, evaluation guides, and strategies for the application of health programs, to recommendations regarding contracts, the organization of clinical services in occupational health, and other administrative issues. Under the leadership of Drouin and with about a dozen members, the Committee's strategy was clearly to mobilize DSC expertise as a valuable resource in its relationship with the CSST, and to secure the status of coordinator of the health network with respect to the occupational health dossier.

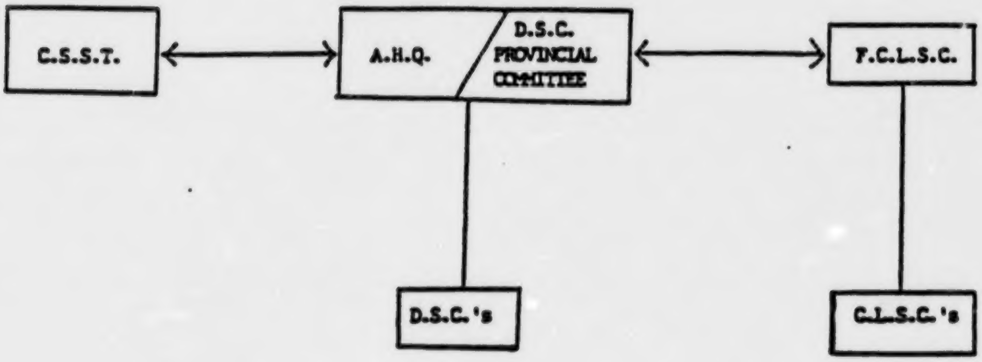
This activity of the DSC's Provincial Committee was itself an important resource for the Regroupement des DSC, in its negotiations with the AHQ. The Regroupement was able to suggest that it controlled the scientific and professional elements of the occupational health dossier, as well as the element of uncertainty regarding inter-establishment relations in the network. It's statements of intent also suggested that it had the pragmatism to play by AHQ-CSST negotiating rules.

By May, 1986, the restructuring of the AHQ to include the Regroupement des DSC, was formalized. All the structures of the Regroupement were integrated more or less intact into the AHQ organigram. The original Community Health Division of the AHQ was expanded to include a spectrum of sub-committees, variously related, including a Community Health Co-ordination Committee, which includes a Community Health Council, the DSC's Provincial Committee for occupational health, and an Occupational Health Orientation Committee - which is concerned with strategies vis à vis "third parties". With this restructuring, the Regroupement was dissolved. The ADDSC continues to exist as a small professional organization for DSC chiefs.

We must recognize, however, that not all DSC's were pleased with this development. It was brought about on the basis of very strong leadership on the part of a few individuals, who were prepared to devote much time and energy to the political aspects of the DSC's situation. Despite an initial round of lobbying throughout the province, many DSC chiefs, coordinators and professionals had simply not participated in nor pronounced on the changes. Although they may not have been pleased to recognize the AHQ as their official representative, many chose not to "politic" against the new leaders that had emerged, either because they recognized that greater divisiveness within the network might be disastrous for the DSC's role in the occupational health dossier, or because they felt that the "movement" to join forces with the AHQ could not be stopped.

But there was some evidence of a lack of consensus among the DSC's, at least in the earlier years of the rapprochement. This was not only expressed in the time it took to achieve an official agreement (about two and a half years) and in the extent and complexity of organizational "concessions" made by the AHQ, but also in the type of "counter-leadership" that co-existed with the Provincial Committee.

For example, in 1984-85, professionals at DSC-CHUL were working on a major project, the object of which was to define the orientation of the network's intervention in occupational health. This initiative was supported by the Ministry, and the objective was an endorsement by MSSS of the "community approach" to occupational health intervention. This goal was evidently in competition with the goals of the DSC's Provincial Committee which, as we have pointed out, was far more pragmatically inclined. The Provincial Committee/AHQ was concerned first and foremost with "managing" the occupational health dossier, according to its mandate under the LSST and the CSST/DSC contracts. The MSSS/DSC-CHUL initiative, on the other hand, was concerned with legitimating a particular "style" of intervention, usually associated with the CLSC's. The development and implications of these parallel orientations within the network are the subject of the next chapter.



the position of the AHQ/Provincial Committee

CHAPTER VIII

ALTERNATIVES: IDEOLOGICAL RIVALRY AND THE POLARIZATION OF POSITIONS WITHIN THE NETWORK

8.1 Abstract

In this chapter, we will examine the role that ideological positions play in relation to the social dynamics of the occupational health system. It would appear that there is an ideological split within the network, marked by a "managerial" approach vs. a "community" approach to both network relations and the means of achieving health objectives in the work milieu. Although expressed in ideological terms, this split reflects rival professional, organizational and systemic interests. Their expression within the health system may be illustrated as follows:

	Managerial orientation	Community orientation
Professional Level	DOCTORS	MULTIDISCIPLINARY TEAMS
Organizational Level	DSC's PROVINCIAL COMMITTEE	FCLSC
Systemic Level	AHQ, CSST	MSSS

8.2 Rival Rationalities

In previous chapters we have seen a climate of defensiveness develop between the DSC's and CLSC's. Ultimately, the CLSC's looked to the Ministry for support in resisting the overpowering DSC-AHQ alliance. On the basis of its 1981 commitment to completing the CLSC network and encouraging decentralization, the Ministry had gradually recruited a number of professionals familiar with and sympathetic to the CLSC's. In 1984, MAS funding was made available for a project entitled _Pour une approche communautaire en santé au travail_. The object was to define a common ideological thread or orientation between the Ministry's objectives, the CLSC mission, and occupational health intervention. This initiative paralleled the rapprochement of the DSC's Provincial Committee and the AHQ, whose objectives, we have pointed out, were far more management-oriented.

It is not surprising, then, that one of the ways in which the DSC-AHQ alliance was manifested was in a deterioration of the relationship between the DSC's and the Ministry. Where once the DSC's had demanded more active participation on the part of MAS in this dossier, now, any initiative taken by Occupational and Environnow, any initiative taken by Occupational and Environmental Health Services with respect to orienting or coordinating the network is devalued by the DSC's Provincial Committee, and often disqualified by the withholding of official DSC recognition, participation and support. For example, although DSC-CHUL played a leadership role in the "community approach" project it was considered renegade, and the project was ignored by the Provincial Committee.

Another example of the distance that has developed between the DSC's and the MSSS is the Ministry's Provincial Coordinating Committee. This committee was initiated by MAS's Occupational and Environmental Health Services in 1985, for the purpose of arriving at a network consensus on relations with the CSST. The objective was to ensure that, at meetings of the MAS-CSST Joint Standing Committee, there would be a coordinated and united position presented by all network representatives with respect to the identification and resolution of contentious issues.[13] Altogether, about four meetings of the MAS Coordinating Committee were held, before the DSC's Provincial Committee/AHQ withdrew DSC representation, on the grounds that "nothing important" was being accomplished.

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[13] Sitting on the CSST-MSSS Joint Standing Committee are representatives of the AHQ, the FCLSC, the Conférence des CRSSS, as well as the Ministry. A CSST representative chairs the committee, which has no decision-making power, but is simply a forum for communication.

Who is it that defines what is "important" for the network and what is not in the occupational health dossier? This is the essential question around which a polarization of the network has evolved. The stakes are the right to impose "criteria of rationality" for discourse and action within the system.[14] The group that imposes its own "criteria of rationality" ensures that, whatever decisions may be made regarding the system, its own interests will not be undermined. Does the DSC's Provincial Committee, representing an alliance between DSC's and the AHQ, have sufficient resources to control the definition of what is rational, important, necessary for the successful involvement of the health network in occupational health? Or can (and should) the Ministry summon the needed resources to assume that role?

There are several levels at which this issue is being contended. There is the systemic level, that is the level of the political decision-makers who determine policy. These include not only the upper levels of the

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[14] "Criteria of rationality" refer to the parameters of what will be considered a "reasonable" decision or solution. For example, the decision to use the MAS network for occupational health services rather than set up a parallel service attached to the CSST, was dictated by financial "criteria of rationality".

Ministry which may negotiate with the Ministry of Labour and the CSST executive, but also "political" associations such as the AHQ, the CPQ and the FTQ. An equivalent contest is being waged in the field, however, at the organizational level and at the level of the professionals. Doctors make a claim for their professional expertise, while other professionals decry the medicalization of occupational health. The DSC's insist on the centrality of their role as the planners, coordinators and evaluators, while the CLSC's insist upon their monopoly of the "community approach" to intervention, and its primacy in the occupational health policy. At each of the levels of interaction - inter-professional, inter-organizational and systemic - an ideological polarization appears to have developed out of the general incoherence of network participation in the dossier.

8.3 The Professional Debate: Is Occupational Health a "Medical" Issue?

On one level, the question of who sets the criteria of rationality, or who decides the parameters of an "appropriate" decision in occupational health, is experienced in the form of a certain tension between doctors and other professionals - particularly nurses - practicing in the field. The LSST stipulates that a physician who has been certified by the DSC, and chosen by the health and safety committee of a workplace, is responsible for the application of health programs (the *médecin responsable*). In reality, occupational health teams, consisting mainly of nurses, but also industrial hygiene technicians, health educators and others, carry out all regular tasks associated with the development and implementation of health programs.

In many cases, the doctor in charge routinely signs these programs, having assured himself or herself that the health and safety committee of the work establishment - where such a committee exists - is satisfied. Other doctors attempt to assume a more authoritative role, actively ensuring that the teams function according to given procedures and schedules. Certainly, then, individual attitudes affect the extent to which inter--professional tension is experienced.

However, almost all doctors share the opinion that they must have "functional authority" over other professionals, including nurses and technicians. "Functional authority" refers to authority with respect to medical decisions and medical acts, of which only physicians "know" the criteria of rationality. But in occupational health, the premise of this assumption is challenged, especially by those nurses who usually perform the services.

They tend to argue that prevention is not a medical act, nor an activity requiring medical expertise beyond that provided through consultation and technical support (research, evaluation, etc.). Rather, prevention requires expertise in evaluating the work environment and job characteristics, in health education and consciousness raising, and in monitoring both the workers and the work milieux. According to certain professionals, then, medical rationality is "irrational" when applied to prevention in occupational health. They criticize the "medicalization" of occupational health which supposedly focuses more on expert medical attention, than on the encouragement and support of workers and employers to take charge of their problems with some information and training of their own. Prevention, it is argued, requires multidisciplinary services in which the role of the medical doctor is minor or even non-existent.

Indeed, there is some ambiguity as to what constitutes a medical, or clinical act in occupational health. Recognizing this, a special task force of the DSC's Provincial Committee is currently working towards the development of a "clinical service" in occupational health, to be attached to each DSC. One of the objectives of this endeavour is precisely to define and support the clinical aspects of occupational health decisions and activities. But it would also ensure that doctors retain their functional authority over occupational health teams, and their right to define the parameters of proper practice, on the basis of their clinical expertise.

Not only doctors, but most professionals are uncomfortable with the normative approach of the CSST, in which the application of the health program involves little more than ticking off boxes on a form. But the physician in particular is also uncomfortable with the "auxiliary" role he would hold given the criteria of rationality associated with a "multidisciplinary" approach. For the doctor's autonomy to be protected, his or her "functional authority" vis à vis co-workers must be defended. Otherwise, switching to private practice is almost always an option. Thus the concerted effort to reinforce the role of the physician in the occupational health system is partially a response to problems of recruitment and turnover in the public sector. While the legal and expert _authority_ of the doctor are usually emphasized by both sides in the "debate", what is really at stake is _autonomy_ for all professionals concerned.

8.4 Organizational Rivalry: a "Management" or "Community" Approach?

Doctors vie with nurses, health educators and others for the power to impose their respective criteria of rationality for the decisions and activities of occupational health professionals. This "competition" is experienced in the field as frustration and loss of autonomy - and eventually demotivation - for one professional or another. On the other hand, the "battle" is not usually fought between the professionals themselves. Rather, it has been taken up by the organizations of which they are a part, that is, the DSC's and the CLSC's, which incorporate it into their own bids for institutional autonomy.

An example of this process is the DSC's Provincial Committee's promotion of "clinical departments" for occupational health. This strategy is designed to ensure the autonomy of occupational health physicians, by grouping them into peer-controlled clinical departments attached to the DSC's, instead of allowing them to fall under the authority of non-medical CLSC coordinators. While providing professional security for the doctors, this strategy also aims to secure the DSC-affiliation of occupational health physicians, and thereby, DSC control over the CLSC's occupational health interventions.

The strategy is part of an overall effort on the part of the DSC's Provincial Committee to gather, develop and support the expertise that it deems necessary for the successful management of the occupational health dossier. Its definition of the "necessary" type of expertise - in fact its definition of "success" vis à vis the occupational health dossier - must be accepted if its leadership role is to be both formally and informally acknowledged. CSST support is in the background, in the guise of the AHQ. But its status is still challenged by the FCLSC and it may conceivably be threatened as well by impending reforms to the LSST, which have been announced, but not yet defined, by the Minister of Labour.

In what terms does this organizational confrontation manifest itself? There are now two orientations within the network, one represented by the DSC's, the other by the CLSC's. But close examination of the content of these orientations reveals that they do not actually oppose each other. On the one hand, the DSC's Provincial Committee has outlined its criteria for rationality in terms of good management; on the other hand, the CLSC's describe their criteria of rationality in terms of appropriate intervention.

Objectively, both orientations are required for the success of the network's mandate in occupational health, and there is evidence that this is understood by both parties. Yet there has been a polarization of discourse, which has impeded the complementarity that might otherwise exist between the two.

One pole of discourse revolves around the community health orientation. The "community approach" refers to a style of intervention associated with the CLSC's, and one which they would like to see endorsed by MSSS as the "official" orientation of the network in occupational health. It implies three basic elements: 1) an approach centered on the work milieu, and the participation of workers in the definition and resolution of their problems; 2) a global or multidisciplinary approach, in which occupational health intervention is integrated with other forms of intervention focusing, for example, on the workers' home life or socio-economic conditions, and 3) a preventive approach, centred more on information, animation and support than on laboratory and clinical tests and medical examinations.

This discourse is not maintained by the CLSC's alone, though one of its objectives is to promote the CLSC's role in occupational health. In fact, it was initiated by professionals from Occupational and Environmental Health Services (MSSS) and from DSC-CHUL, in the project entitled Pour une approche communautaire en santé au travail: un cadre de référence. The project, begun in 1984, included an evaluation of the experiences of occupational health professionals in the field, the elaboration of several research documents, and the organization of a conference (ASPQ, May, 1985) in which Ministerial support for the community approach was publicly expressed. A second colloquium, this one organized by the FCLSC in September 1985, further elaborated on the "global and preventive approach in occupational health", with a special focus on the integration of occupational health with other CLSC programs. The Ministry's interest in the community approach has its roots in the more global decentralization policy and the promotion of the CLSC's mission within the network. The support of some DSC's, on the other hand, goes back to their own "community health" roots, which are ideologically akin to those of the CLSC's.

The "CLSC offensive" was not confined to the elaboration and promotion of parameters for intervention in occupational health. It included action of a strictly political nature, designed to distinguish the CLSC's position and strategy vis à vis the CSST, from that of the DSC's. In a 1985 meeting of the CSST-MSSS Joint Standing Committee, an FCLSC representative declared, to the equal consternation of the CSST and the AHQ representatives present, that the CLSC's would not be signing further contracts until certain modifications had been arranged. The implication was that the CLSC's had sufficient resources behind them to influence the criteria of rationality.

This move emphasized, to both the DSC's Provincial Committee and the Ministry, the need for an integrated strategy. It was at about this time, after two years of effort on the part of Occupational and Environmental Health Services, that the Ministry managed to organize the first meetings of its Provincial Coordinating Committee to synchronize network strategies in dealing with the CSST. As we know, after several meetings, the DSC's

Provincial Committee withdrew its participation and the MAS Coordinating Committee died. At one of those meetings, however, a working document entitled *Projet d'un cadre de référence pour une approche communautaire en santé au travail* had been presented for study and comment by the organizations of the network. The objective was to finalize a document which would define the network's orientation with respect to occupational health, and would be officially endorsed by MSSS.

The DSC's Provincial Committee never responded to the document. In line with its more "managerial" orientation, it rather invited the FCLSC to participate in a technical committee of its own to study the contested CSST contract.[15] It rejected the Ministry's effort to play a coordinating role for the network in the occupational health dossier, and it refused to acknowledge the Ministry's attempts to define an "official" orientation with respect to intervention. According to its interpretation of the LSST, these were roles that belonged to the DSC's.

Yet in the AHQ's *Bilan et Perspectives* (1985), one of the recommendations is that a common *cadre de réfé-*

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[15] Agreements on some administrative irritants were reached, but the contracts remain unsigned by the CLSC's at this date.

rence be established for the network with respect to occupational health intervention. And the Committee's professed philosophy suggests a certain sympathy with the community approach:

> ...la philosophie qui est à la base de (la santé communautaire) en est une d'action devant mener à l'application de programmes pour améliorer l'état de santé de la population, et ce par le biais de la prise en charge du problème par la population, assistée et supportée par les intervenants.
>
> Comité Provincial, 1986

However, in the same document, as in other statements of the DSC's Provincial Committee, its real orientation appears to be a bit more instrumental than suggested by its "philosophy". Emphasis is rather placed on the need to define specific objectives with respect to the workers' state of health and environmental risks; these objectives must be "precise and measurable", with a deadline for achievement attached to each of them. Four stages to the process are defined: 1) prioritization, 2) programming, 3) co-ordination of resources, and 4) evaluation.[16] This orientation demonstrates more of a concern with the mechanisms of managing the dossier, than with the style of intervention practiced in the field.

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[16] On the basis of a presentation by Mme. Forget in November, 1986, at a CPQ-sponsored conference, and on the basis of a presentation by M. Bertrand in December, 1985, at an FCLSC-sponsored conference, the orientation of the DSC's Provincial Committee as outlined in its document Pour une définition d'objectifs de santé is shared by the CSST.

But is it an orientation which opposes the community approach? Rather than opposing, it would appear to complement the community approach. One reflects the particular mandate of the DSC's, and the other the particular mandate of the CLSC's. Is the polarization of organizational ideologies therefore an illusion?

If it is an illusion, it is a strategically created illusion. For, rather than promoting complementarity, each institution either plays down the role and the importance of the other, or suggests that it could just as well fulfill the role itself. For example, in the DSC's Provincial Committee's _Pour une définition d'objectifs de santé_, the CLSC's are mentioned only as an alternative agent for health education programs. Such programs, the document suggests, can also be implemented by the private sector, and it points out that a number of DSC's are currently developing an expertise in the field themselves (pg. 12). The impression created is that ultimately, there is no real need for CLSC participation in the dossier at all.

The Federation of CLSC's is following a similar strategy. In a March, 1985 document entitled *Pour un modèle de responsabilités sous-régional en santé communautaire*, there is praise for complementarity as an ideal, but pessimism with respect to its attainment. Just as the DSC's Provincial Committee suggests that there may be no real need for the CLSC's, so here, the FCLSC suggests that the CLSC's have no real need of the DSC's. It asks whether the responsibilities entrusted to the DSC's do not merely reflect the underdevelopment of the CLSC's:

> ...si (les DSC) se relèvent incapables de répondre à (nos) besoins et attentes, les CLSC n'auront vraisemblablement pas d'autres choix que d'envisager la possibilité de se doter euxmemes de ce type de ressources et des mécanismes de concertation et de support nécessaires pour y répondre.
>
> Lalonde, 1985

Why do we find a tendency on the part of both DSC's and CLSC's to polarize their positions, rather than integrate them? We must remember that at this point in time, 1985 to the present, there has not only been a high level of uncertainty in the system, but the resolution of that uncertainty may be directly threatening to either or both of these organizations. New government, new leadership at the CSST, intensified lobbying by the CPQ for full privatization of occupational health, financial pressure on the CSST, a commitment to legislative changes, Ministerial committees of inquiry into the role and functioning of the CLSC's and the DSC's - all of these sources of uncertainty create a vacuum with respect to the criteria of rationality for decisions and actions within the system.

Under threatening conditions, the instinct is to preserve autonomy, the capacity to determine one's own actions and responses. Complementarity is itself a threat to autonomy, to the extent that it creates boundaries beyond which one must depend on others. When everything is being questioned, when the rules of the game are being redefined, it is far better strategy to emphasize independence rather than interdependence. When new structures may be in the making, it is far better strategy to create the illusion of being indispensible to the system, rather than being one of many (spare?) parts. Thus, if the decision-makers can be convinced that "good management" is the key to success, and that the DSC's Provincial Committee has a monopoly on "good management", then the DSC's status gains some support. On the other hand, if the decision-makers can be convinced that a "prise en charge" by the milieu[17] is the key to the success of occupational health, and that the CLSC's are more suited to that job, then their role in the system becomes essential.

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[17] "Prise en charge" may be translated as "taking responsibility" or "taking charge". Since the expression has become a slogan for the popular appropriation of government-run services and programs, we have chosen not

The organizations have had to seek out allies in their efforts to promote their own roles and functions. The alliance of the DSC's Provincial Committee and the AHQ on the one side, and the alliance of the CLSC's and the Ministry on other side, has exaggerated the polarization within the network. Furthermore, the AHQ and the Ministry do not entirely share the interests of their "client" establishments, or at least, they have certain interests that are of a different order. Therefore, while negotiations at the top will have a significant effect on the relations between DSC's and CLSC's, they ultimately revolve around different stakes than those at play within the network.

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to translate it.

8.5 The Systemic Issues: Autonomy and Accountability

Changes to the occupational health and safety system are currently being contemplated for a whole series of reasons which are far beyond the scope of this report. What is pertinent here is that, since the Ministry of Labour has embarked on a reform of the policy, the time is ripe for introducing some changes with respect to the involvement of the public health network. Both the AHQ and the Ministry would like to come out of this time of uncertainty in a more autonomous position with respect to the occupational health dossier.

The stakes in the contest between the AHQ and the Ministry ostensibly revolve around autonomy and accountability. On the one hand, the mission of the AHQ is to defend the autonomy of the hospitals, and their responsible position with respect to occupational health. Since the hospitals are accountable to the CSST by virtue of their contracts, then the CLSC's must in turn be accountable to them.

On the other hand, the Ministry functions on the assumption that the interests and objectives of the network as a whole are not identical to those of the

AHQ. To impose AHQ or hospital-related objectives on the CLSC's for example, would jeopardize not only their autonomy, but the logic, the rationality, the complementarity of the network as a whole. Therefore, accountability within the network must be directly to Ministry, who co-ordinates the "big picture".

Underneath these concerns regarding the prerogatives of network establishments, lies another issue: who controls the $40 million budget associated with the dossier? Both the Ministry and the AHQ have been playing to manage this money in their own interests[18], but their maneuverability is limited by the fact that the CSST holds the purse strings. But the autonomy of the CSST is limited as well, by the legislative power of the Ministry of Labour, and especially by the ultimate interests of the members of its own board of directors.

So far, the CSST has felt more at ease dealing with the AHQ than with the Ministry, for all the reasons that have been mentioned in previous chapters. But the Ministry has some important arguments against CSST-AHQ collusion in this domain. The disposition of $40 million has the potential of making a significant impact on the functioning of the entire health and social service network. For example, a decision on the part of the CSST to institute a major budget cut might be handled very differently by the AHQ than by the Ministry. The AHQ might be concerned mainly with the problem of fulfilling the obligations of its contract on a severely reduced budget, while MSSS would be concerned mainly with the disruptive effect on the network, that is, the displacement of personnel and other resources.

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[18] We will remember that the Ministry's *politique cadre* had as its objective the dispersement of CSST funds to the CLSC's.

What the AHQ has to offer the CSST, in its bid to maintain the existing "coalition", is a willingness to commit itself to the efficient management of the CSST/-CH-DSC contract - in other words, an acceptance of its accountability to the CSST. This is a valuable resource for the CSST, which is itself accountable through its board to the private sector. The Ministry of Health and Social Services, on the other hand, can claim autonomy with respect to the CSST. In the present context it is seen by the CSST as a rival for network support, rather than a guarantor of that support.

What resources, then, does the Ministry have to mobilize in a bid to take over the co-ordination of the network with respect to occupational health services? At this level, its complete autonomy with respect to its negotiating partners is an important resource. It is not constrained by contracts or even the law which, it may argue, can always be changed. But to justify any claims it may make to appropriate control of the dossier, it would likely have to fall back on its ideological position, namely, that the technocratic orientation of the CSST-AHQ-medical profession will not achieve the objectives of the Occupational Health and Safety Act; that those objectives can only be achieved through the integration of occupational health with other public health programs, and that they call for a community approach encouraging a *prise en charge par le milieu*.

CHAPTER IX

SYNTHESIS AND CONCLUSIONS

9.1 Summary of Findings

The objective of the preceding analysis was to expose the formal and informal dynamics surrounding the involvement of the public health network in occupational health and safety. During the seven years since the adoption of the Occupational Health and Safety Act (1979), the health network's participation has been marked by conflict, demotivation, disorganization and delays. The role of the network in the overall policy is minimal - health services represent only about 3% of the budget of the CSST. But the management of the dossier has had an important impact on the network. It played a significant role in the development of the both the DSC's and the CLSC's, encouraged a mobilization and reorganization of the AHQ, and polarized the network over professional, organizational and ideological differences.

To examine the full complexity of the occupational health and safety system was beyond the scope of this analysis. We have had to put aside a number of issues of significance to the functioning of the system as a whole - for example, the internal dynamics of the CSST, the role of the sector-based associations, the organization of prevention within the workplace, and so on. But these are more or less peripheral to the dynamics of the health network. The focus of the study has been the structures of the public health network, and their functioning within the context of the occupational health system.

9.1.1 The Heritage of the System

The Occupational Health and Safety Act represents, in its origins, a series of improbable compromises calling for extensive political, organizational, and professional adjustment to new rationalities and new rules. The Act has a triple heritage: 1) **technocratic**, which was the legacy of its predecessor, the old Workman's Compensation Board (CAT), which had evolved since 1928 into a huge, bureaucratic insurance company much maligned by employers and unions alike; 2) **political**, in the sense that it was one of the first pieces of major legislation to be brought out by the Parti Québecois government, and to the extent that it was largely inspired by the FTQ; and 3) **professional**, on the basis of newly-developing expertise in the fields of prevention, occupational health and industrial hygiene within the Community Health Departments (DSC's).

The compromises between these traditions were not made out of a particular desire to respond to the priorities of three divergent world views, but were imposed by administrative, political and financial imperatives as interpreted by Pierre Marois and his cabinet in 1979. Each group had significant input during the deliberations leading up to the White Paper of 1978. The new Director of the CAT - viz. the CSST - spoke for efficient administration; the FTQ and the CPQ represented the political forces; and the Treasury Board laid down financial limitations.

Of the three founding traditions, then, the community health influence was the weakest. The role that was ultimately assigned to the public health network was imposed on the basis of financial constraints, while being strongly opposed on both administrative (technocratic) and political grounds.

a) Administrative Opposition to the Involvement of MAS

In 1978-79, the institutions of the community health network were new, knowledge and experience were still limited, and the CLSC's especially were considered radical and untrustworthy. The professionals associated with the Ministry of Social Affairs (MAS), the DSC's and the universities were committed to the structural separation of prevention and compensation, with MAS in charge of prevention. But the Minister himself did not put his weight behind their demands; the occupational health dossier was the responsibility of Marois, Minister of State for Social Development, while Lazure, Minister of Social Affairs, had other concerns of his own.

For his part, Marois was intent on consolidating the various responsibilities and mandates related to occupational health, which had been dispersed chaotically throughout a large number of government ministries, agencies and organizations. The Ministry of Social Affairs did not figure in his plans.

The primary reason the network was granted any mandate at all within the new legislation was financial: the Treasury Board had vetoed the first choice of Marois and the CSST, that is, the development of a parallel public health system attached to the CSST. But Marois was committed to dismantling the existing system based on private company doctors. Strong reservations regarding the participation of the MAS network were eventually over-ruled by the decision to establish a direct contractual liaison between the CSST and the hospitals, bypassing both the CLSC's and the Ministry. It was compromise that was reluctantly accepted on all sides. As the system stands, the network now serves two masters: the CSST on the one hand, and the MSSS on the other.

Living with this compromise has brought problems of adjustment to both the CSST and the health network. The CSST is highly centralized, bureaucratized, legalistic in its orientation, but ultimately controlled by political forces; the health network on the other hand is decentralized, loosely integrated, oriented towards its own professional interests, and not always controllable at all. **For the CSST, these differences are handled through a highly controlled delegation of responsibility to the DSC's: little decision-making power or flexibility is left to them in terms of managing their budget or the content of their work.**[19]. They are controlled by means of the contract, and in turn - through sub-contracts - these same controls are imposed by the DSC's on the CLSC's.

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[19] For example, transfers from one protected budget to another are not permitted, nor are deficits. In 1985, a "surplus" of almost $3 million was recuperated by the CSST from the DSC's with respect to their separate

b) Political Opposition to the Public Health Component

The political forces within the CSST - that is, the union and employer representatives who sit on its board of directors - have remained opposed in principle to the participation of the public health network in occupational health. The FTQ is committed to parity relations, and would therefore prefer that expert support for managing prevention be provided through the sector-based associations alone. These, however, are far from being fully effective even for priority industries, though they are beginning to claim a greater status in the system. Furthermore, the union would gain more mileage with its members if it were able to show concrete benefits to individuals, in the form of "medical services"; preventive medicine, especially public health measures, are not "experienced" individually and are therefore more difficult for the unions to "sell".

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budgets for base teams and health programs. This surplus resulted from the inability of the DSC's to fill all positions and to complete all health programs in the allotted time.

The CPQ is even more uncomfortable with the role of the public health sector, since this role represents to them the State appropriation of control over conditions and employees in their private enterprises. Their strategy has been to denounce the "bureaucrat-doctors" ("médecins-fonctionnaires") and to demand "services" for their CSST premiums. The appearance of productivity has thus become the primary concern for the CSST in the realm of prevention, and has been translated into pressure on the DSC's to produce health programs of a uniform type - regardless of the specific needs of a work environment - and to produce them with given resources and within given time frames.

Subjected to these political and administrative requirements and criteria for evaluation, the practice of public health has been severely compromised. This has resulted in the demotivation of many professionals and their withdrawal from the system, and indeed, high rates of turnover have been one major source of inefficiency. Ultimately, this situation makes it much easier for the FTQ and the CPQ to promote their own agenda: in showing up the inefficiency of the public network, they can justify their attacks on the community health component of the policy, and call for the privatization of occupational health services.

9.1.2 Two "Masters", Two Sets of Rules

The compromise that was struck in the occupational health Act, in which health services are provided by the public health network under the authority of the CSST, created a contradiction in the system. The CSST has the responsibility of establishing priorities for intervention and assessing interventions (LSST, art.167 (1) & (11)). Its contractual relation with the hospitals binds the DSC's to decisions and regulations adopted by the CSST with respect to intervention. The Ministry of Health and Social Services, however, maintains ultimate responsibility for the establishments of the health network, which include the hospitals and their DSC's, and for coordinating personnel and the services they provide (LSST, art. 167(9) & (16), art. 168). As a result, the health network essentially has two masters, and given the disparity between their organizational structures and cultures, the network must "play the game" in accordance with two very different sets of rules.

How is this contradiction manifested within the system? Normally, a number of opposing objectives and rationalities are juggled within any organization, but the juggling itself follows certain rules which ensure that, despite various "secondary games", the primary job at hand gets done. In the case of the occupational health and safety system, however, the stakes are such that **the DSC's and CLSC's find themselves subject to significant gains or losses, depending on which set of rules they identify with. The stakes include their position within the system, their margin of autonomy, their access to resources and the legitimacy of their missions.**

Accordingly, the DSC's tend to refer to the special responsibilities granted them in the LSST, and their discourse focuses on their qualifications for managing the mandate. The CLSC's, on the other hand, refer to the word and spirit of the Health and Social Service Act (1971), and to the Ministry's *Politique cadre d'administration des services de santé au travail de première ligne* (1982). Their discourse focuses on front-line intervention. Although neither denies the importance of the other's concerns, the stakes lead them to take defensive attitudes and to develop a climate of confrontation.

a) The DSC's: Responsibility without Control

The effect of introducing the politique cadre into the occupational health and safety system might have been mitigated, had the organizational cultures of the CSST and the Ministry been more compatible. But under the circumstances, the objectives of the CSST-DSC contract and the objectives of the politique cadre are in fact contradictory. The CSST-DSC contracts are designed to reduce uncertainty for the CSST by stipulating the expectations that the two contracting parties can legitimately have of each other. The DSC-CLSC contracts - signed in accordance with the politique cadre - are designed to implement complementarity in the network and the attendant distribution of resources. The latter objectives nullify the former, since many expectations that the CSST may have of the DSC's are no longer under the DSC's control. In a sense, the system is short--circuited.

The politique cadre was a catalyst for the polarization of the system. Implemented in a period of economic recession and budget cuts, there was no new money available for the development of the CLSC's. Decentralization therefore had to take place at the expense of the other establishments of the health and social services network, that is, the Social Service Centres and the DSC's. Occupational health contributed considerable resources to the DSC's - the base teams alone had meant five new positions for each DSC, and they had begun to recruit more personnel for the production and application of health programs. Under these circumstances, the transfer of all resources (but the base teams) to the CLSC's was a considerable loss. It also came at a time, in 1982, when the occupational health teams were still new and inexperienced. On the one hand, the DSC's remained responsible for the health programs, as per their contracts with the CSST. On the other hand, the politique cadre threatened the DSC's of control over the means of production.

b) The CLSC's: More Security, Less Autonomy

The Ministry's 1981 policy statement, Le Réseau des CLSC du Québec: un parachèvement qui s'impose, was the first assurance the CLSC's had received that the government was committed to their continued existence. The politique cadre for the decentralization of occupational health services was the first specification of mechanisms for decentralization. There were several reasons that it was published early, and as a separate document.

First, occupational health did not fall in with other community health programs, which were administered by the Ministry of Social Affairs. Second, the Ministry sought a quick solution in the case of this dossier, before the CSST contracts - including the disposition of funds for Group I industries - were signed by the DSC's. And third, the directive served as some assurance to the CSST that the decentralization process would proceed in an orderly fashion. Some CLSC's barely benefited from a transfer of resources if enterprises in their territories were not amongst Group I priority industries, while other CLSC's incorporated three or four new positions. Although the new resources represented a CLSC "victory", the official declaration of a CLSC monopoly over front-line occupational health services was the more significant gain in terms of their future.

There were considerable differences in terms of the protection of CLSC autonomy, between early versions of the _politique cadre_ and the final, official version. Some issues of prime importance to the CLSC's were left vague, since the Ministry either could not freely pronounce on them, or chose not to. For example, the administrative and professional disposition of the physician in charge of a work establishment (the _médecin responsable_) was ultimately left undefined, though in earlier versions of the _politique cadre_ these doctors were deemed to be attached to the CLSC's from which they worked. Likewise, provisions for DSC-CLSC concertation and the role of the CRSSS were significantly diluted. The final version was tempered by a careful legal analysis to avoid any contradiction or ambiguity with respect to the LSST.

Furthermore, we should recall that the LSST does not leave much room for autonomous CLSC participation. The CLSC's are mentioned in the LSST but once, as follows: "A hospital centre in which there is a community health department _may_ enter into a contract of service with another hospital centre or a local community service centre, under the terms of which the latter undertakes to provide specific health services to an establishment" (LSST, art. 116).

With a very limited role for the CRSSS, and no specification of alternative mechanisms for DSC-CLSC concertation, many CLSC's easily became simple "service points" for the DSC's. Personnel for their occupational health and safety teams is usually trained at the DSC. The teams remain under the "functional authority" of the physician in charge of the workplace (_médecin responsable_), and therefore under the authority of the DSC. The members of these teams, linked as they are to the DSC's and in many cases transferred directly from the hospitals, rarely share the culture of the CLSC - that is, the commitment to a particular approach to intervention, professional interaction and organization. Unless the team has more than 126 members, there is no coordinator provided for the occupational health program. Not only the schedule, but the content of intervention is determined by CSST norms, passed on via the contract to the DSC's, and from them to the CLSC's. Thus the role of the CLSC program coordinator is neutralized. Bureaucratic demands are much greater on the Director of the CLSC than for any other program.

In the final analysis, the CLSC's have not been able to integrate the occupational health teams into their organizations, nor have they been able to integrate the occupational health program with their other programs. It is a dossier which is managed on the premises, but is cut off from the CLSC organization in most ways.

c) A Polarization of the Network

There have been several interesting responses to the reality of decentralization. The CSST, for one, responded by "denying" the official entry of the CLSC's into the system. The DSC's, through the AHQ, remained its only contact in the network, and until the end of 1985, there was no discussion of CSST-CLSC cooperation, at the local or any other level. All directives or complaints with respect to front-line services continued to be directed to the DSC's. The presence of the FCLSC on the MAS-CSST Joint Standing Committee could also be ignored, since this was not a decision-making committee. In other words, **the CSST imposed the rules of the game as though the politique cadre did not exist. The Ministry of Social Affairs had the authority to institute a reorganization of its own network, but it could not force a reorganization of relations between the CSST and the network.**

Unlike the CSST, the DSC's could not passively ignore the politique cadre, though some used delay tactics, or introduced specific clauses into their CLSC contracts to mitigate its effect on their ability to control the means of production. It would appear that, given the introduction of new rules, there was some expectation that MAS would intervene with the CSST in face of that organization's resistance to adapt. But when this intervention proved to be only of an informal and limited nature, and undertaken only under duress,[20] the DSC's Provincial Committee sought to prepare its own "offensive".

Under new leadership its objective was to increase the DSC's margin of autonomy with respect to both MAS and the CSST, and to consolidate their control over occupational health services produced by the CLSC's. Towards this end, the LSST and the AHQ were far more promising resources than the politique cadre or the Ministry's Occupational and Environmental Health Services. The DSC's had more to gain by playing the CSST's game.

The CLSC's, however - given the CSST's "denial" of their newly established place in the system - put their fate in the hands of the Ministry. The politique cadre had guaranteed them a role in occupational health. But this was only an administrative policy, and did not truly legitimate that role. The CLSC's then expected that MAS would develop a "content" policy, that is, an official definition of the network's orientation in occupational health. And indeed, the Ministry embarked upon le projet d'un cadre de référence pour une approche communautaire en santé au travail.

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[20] We refer here to the CSST request to MAS that four DSC's be put under trusteeship for non-delivery of health programs (1984).

However, the colloquium organized around that subject was not very well attended by the DSC's, and the working document produced by MAS was "officially" ignored by the DSC's Provincial Committee. Discussion of the community approach was deemed impolitic and irrelevant in its definition of the situation. Without significant support from the DSC's, the Ministry's adoption of the cadre de référence pour une approche communautaire and the attendant legitimation of the CLSC's occupational health role was unlikely.

The DSC's, including their Provincial Committee, rarely argue against the community approach to intervention. They do, however, suggest that it is an unrealistic game plan in the context of CSST rules. They have little to gain, and some credibility to lose with the CSST in defending the community approach. The CLSC's, on the other hand, rarely argue that they have the resources to manage the occupational health dossier single-handedly, in terms of planning, technical expertise and impact evaluation. But they do argue that the DSC's overstep their mandate within the health and social service system, by trying to co-ordinate and control front-line operations. In other words, with the CLSC's playing in the Ministry's courtyard, and the DSC's playing in the CSST's courtyard, any common ground between the two evaporates into an atmosphere of mistrust.

9.1.3 Informal Adjustments: "Power Abhors a Vacuum"

In any system, but especially in a relatively new system, areas of uncertainty exist and unforeseen circumstances arise. The occupational health system in particular was an untried model. It combined political, administrative and professional elements in a way that was completely foreign to the public health sector, and there was no precedent or experience on which the establishments and their personnel could rely to guide their decisions and actions. The authors of the policy had been in a similar situation, and had - by design and chance - left room for adjustments "in the field". These zones of uncertainty are like vacuums which beg to be filled. Their existence motivates actors to compete for and claim more autonomy or authority than had been provided for them in the law.

a) DSC's and CLSC's: Assuming a "Responsible" Role

The system that was created by the Act provided for a purely supportive role for the network: the identification of health risks and the preparation and application of specific health programs for each enterprise ("secondary prevention"). "Primary prevention", that is, the establishment of specific mechanisms to prevent illness and accidents, is the responsibility of the private sector. There is an interdependence between the two which should ultimately be ensured through the role of the health and safety committee in a workplace. But the regulation for health and safety committees in priority industries was not adopted by the CSST until 1984, long after the CSST-DSC contracts for health services in Groups I and II industries were signed. Likewise, to date there are still priority industries which are not served by a sector-based association, whose role is to develop expertise and support for primary prevention. The upshot is that a vacuum is created by the underdevelopment of pivotal elements of the system.

With its expertise as a resource, the public health network has been able to fill, to some extent, these informational and organizational gaps. But at times it overlaps with the legal responsibilities of the employer, for example, to determine the means of eliminating identified risks. At other times it overlaps with the role of the unions and the sector-based associations, as in the provision of certain types of information and support to workers and health and safety committees ("animation"). And finally, it sometimes overlaps with the authority of the CSST itself, in developing health programs that go beyond the stipulated "minimum requirements", and take into account phenomena (e.g. stress) that the CSST would prefer to consider outside the realm of the current policy. **The network's appropriation of autonomy in these areas looms as a constant irritant to the administrative and political leadership of the CSST.**

b) The AHQ: Assuming the Mediator's Role

The development of a controlling role for the AHQ in the system was apparently an unforeseen event. The LSST stipulates that the CSST will contract for health services with 32 CH-DSC's. A standard contract was drawn up by the CSST and approved - viz., negotiated - with the Ministry as provided for in the law. However, in the Standard Contract, there is no provision for any representation of the DSC's in their dealings with the CSST. The CSST-MAS Joint Standing Committee is merely intended for the exchange of information; it is not a negotiating body. And though the Ministry sits on the board of directors of the CSST, it is as an observer and not a voting member. With no stipulation of any other mechanism, both the CSST and the hospital centres having a DSC agreed upon an avenue of communication and negotiation that met their common, immediate administrative interests, namely the AHQ. The AHQ was an employers' association, a former member of the CPQ; it had briefly sat on the board of directors of the CSST as a voting member; it had engaged in contract negotiations with the CSST (or the CAT) for numerous other services. But in this case, given the scope of the CSST-DSC contracts, the AHQ was negotiating considerably more than an administrative transaction.

As mediator between the CSST and the DSC's, the AHQ made itself indispensible to the heads of the DSC's, the occupational health coordinators and other DSC professionals. They had serious concerns with respect to the content of the CSST contracts, which set parameters not only for the administration of the dossier, but for professional practice as well. For example, these contracts stipulated the content of a health program, the number and type of professionals to serve a given number of workers, and so on. The DSC's found many of these parameters unrealistic, insufficiently flexible and an intrusion into their professional autonomy. On the one hand, such concerns were not those of the AHQ, which represents hospital administrators, not professionals. On the other hand, **the only medium by which the DSC's could communicate their own concerns to the CSST was the AHQ. They were voiceless without it. In this manner, the AHQ - with the collaboration of the CSST - appropriated a large degree of control over the network-CSST relation.**

c) The DSC's Provincial Committee: Assuming the Leadership Role

A final example of the manner in which power, like nature, abhors a vacuum, is the DSC's Provincial Committee's assumption of authority vis à vis the rest of the network - i.e., the CLSC's - in the occupational health dossier. During the first three or four years from the adoption of the LSST, a call for more active MAS involvement in the dossier had been sent out by every institution from the CSST, to the DSC's, the FCLSC, and Occupational and Environmental Health Services of the Ministry itself. The demands made of MAS included increased participation in and commitment to training and programming - more specifically, the development of network expertise, and the assurance of integration between the occupational health program and other public health programs. Indeed, the Ministry's responsibility for coordinating the network is acknowledged in the LSST (art. 167 (16)). But what that responsibility implied was a financial commitment of significantly greater proportions than MAS was able or prepared to make in the early 1980's, especially for a policy that was ultimately under the wing of another ministry.

After five years of frustration with the Ministry over its alleged neglect of the dossier, the DSC's Provincial Committee leapt into the gap. It based its claim to leadership on 1) the DSC's nearmonopoly of expertise in the field, and therefore their de facto role as the training ground for most occupational health professionals; and 2) the specific responsibilities of the DSC heads stipulated in the LSST, i.e., supervising occupational health physicians, seeing to the application of health programs, implementing all contracts, and so on (LSST, art. 127). No less important a factor, though, was the arrival on the scene of a number of younger, highly trained specialists who were committed to stimulating and guiding the development of occupational health in Québec.

Expertise served as justification for the leadership role sought by the DSC's Provincial Committee, but it also served as an important resource for obtaining the financial and other support it required to appropriate that role. An alliance was struck with the AHQ. **The benefits to the AHQ included the addition of DSC expertise and loyalty to its resources in negotiating with the CSST. This loyalty also represented a certain coup for the AHQ in its relation with the Ministry. In return, the AHQ was able to guarantee the Provincial Committee an annual contribution of $3,000 per CH-DSC, that is, a budget of $96,000 for a small professional and clerical staff, as well as an outlet for publications and communications. And of course, it offered the DSC's Provincial Committee access to the CSST - and CSST support of its bid for leadership of the network in the occupational health dossier.**

These informal adjustments of the parties involved in the occupational health system create a complex patchwork of relations that obscure the neat structures outlined in the law. As we have seen in the previous chapters, they intersect with other features of the system, such as its polarization over the priority of "game rules". The fact that the DSC's had far more to gain in allying themselves with the AHQ than with the Ministry, has favoured the priority of CSST rules and a deterioration of the position of both the Ministry and the CLSC's. The essential issue, however, remains beyond the scope of this analysis: to what extent do these dynamics jeopardize the objectives of the law, i.e., the elimination of dangers at their source, and the participation of workers and employers in the realization of this goal?

9.2 Key Features of the System

On the basis of the analysis carried out in preceding chapters, it is possible to develop a series of hypotheses regarding the key features of the public health network's involvement in the occupational health system. These may reflect characteristics of the public health system itself, or they may reflect the particular conditions associated with this dossier. In one sense, the occupational health dossier is uncommonly complex and a-typical with respect to the network's usual mode of functioning. On the other hand, the conditions imposed in this unusual context may cause certain tendencies within the network to be exaggerated or to be closer to the surface.

9.2.1 Occupational health policy functions at the intersection of two systems - the CSST-governed system and the MSSS-governed system.

a) The imperatives of the two sub-systems are not compatible.

There are a series of constraints behind each one which determines the orientation each takes towards the problems that bring them together. For example: a major preoccupation for the MSSS is complementarity between the establishments of its network. A major preoccupation of the CSST is the appearance of efficiency to its board of directors. These dissimilar imperatives determine the decisions taken within each sub-system, and thus impinge on the ability of the two to concur with respect to the management of occupational health.

b) The organizational cultures are not compatible.

The internal culture of the CSST is related mainly to labour relations and the bureaucracy, while that of the community health network is related more to professionalism and intervention. The latter culture inevitably implies more autonomy for the institutional and individual members of the system than does the former. This can create conflicts in the meaning of concepts; for example, "responsibility" implies control in the case of the CSST, but function in the case of the health network.[21]

c) Two divergent sets of rules are in force in occupational health.

This creates problems of both accountability and legitimacy for the health network. Activities recognized as legitimate and even a priority by the CSST may be considered illegitimate by the MSSS, and vice versa. Examples: a) the "community approach" to intervention vs intervention based on norms; b) a focus on health problems vs a focus on industrial groups; c) localized and specific solutions vs universal services.

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[21] For example, since the DSC's are made "responsible" for the production of health programs under the LSST, the CSST expects them to maintain control over this production regardless of the fact that front-line occupational health services are, under the LSSS and the politique cadre, the "responsibility" of the CLSC's.

d) Formal and informal links between the CSST and the network are often in conflict with each other.

For example, the Standard Contract is formally signed between the Minister of Health and Social Services and the President of the CSST. But since that signing, all specific contracts with the DSC's, which make reference to resources and norms, have been presented to the AHQ as representative of the signatories, i.e. the hospital administrators. Behind this formal rationale, however, lies an informal reality: the Ministry has only an observer's seat on the board of the CSST, while the AHQ used to be a voting member before it withdrew due to "conflict of interest". It also has past membership in the CPQ. The AHQ is a "known entity" to the board of directors and a more comfortable negotiating partner than the Ministry of Health and Social Services, regardless of the formal structure put in place by the law.

9.2.2 While the DSC's and CLSC's would appear to be "natural allies" in their commitment to community health, the cleavages between the two are closer to the surface than the commonalities.

a) There are clear cultural differences between the DSC's and CLSC's.

First, the DSC's are located within hospitals and run by doctors, while the CLSC's are more multidisciplinary and have a definite antipathy to the high status of the medical profession. Second, the DSC's have a "scientific" approach to their work and take pride in their expertise, while the CLSC's have a "field-work" approach and take pride in their relation to target groups. These cultural differences are the basis for complementarity between the two institutions, but they can also serve to divide them.

b) Both institutions consider their own mission as the pivotal one, and see the other as playing a "supporting" role.

More precisely, the DSC's tend to see the CLSC's as "service points", and the CLSC's see the DSC's as "consultants". These "ethnocentric" definitions of the situation can create conflicts, for example, in co-operating on the development of an information system for occupational health, or in developing instruments for intervention. Each believes that the other's contribution should be supporting their objectives.

c) Social forces have emphasized competing institutional interests of the DSC's and CLSC's.

In the case of occupational health, the implications of the politique cadre are a good example. On the one hand, the DSC's mission does not include front-line services, nor would they want it to. On the other hand, when decentralizing front-line services meant a significant loss of resources and loss of control over a field of action, the response of the DSC's was defensive. Their attempt to retain a certain amount of control was then met by the CLSC's with a defensive attitude regarding their autonomy. The result is a climate of contention within the network.

9.2.3 The decentralization of resources has not led to the integration of occupational health services into the CLSC's.

a) The dissimilarity between the CSST program as defined in the contract, and other CLSC programs is so great as to isolate health and safety teams working in CLSC's.

The health and safety teams follow their own schedules imposed by the terms of the contract, and produce health programs according to norms set by the DSC and CSST. The types of activities that they are involved in have nothing in common with the activities of other CLSC staff. These differences are especially evident where the CLSC also has its own occupational health team, financed from its own budget[22]. These latter teams intervene in non-priority industries or practice a form of intervention that the CSST does not support (e.g., animation, support of accident victims, and so on). The objectives, tasks and "output" of the two teams are so divergent as to preclude the development of an actively complementary relationship between them.

b) The occupational health teams have usually remained under the control of the DSC, despite their location within a CLSC.

The staff is DSC-trained, and under the functional authority of the physician in charge of a workplace, who in turn is associated with the DSC. The usual role of the CLSC program coordinator is void, since there is insufficient flexibility in occupational health services to permit co-ordination with other programs. Thus there is no internal co-ordination unless the team is large enough to warrant such a post from the CSST (more than 12 members). The greatest involvement of the CLSC is administrative, i.e., submitting health programs to the DSC's, filing financial reports, and so on.

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[22] Although about 15 CLSC's had full-fledged occupational health programs of their own when the politique cadre was adopted, we have learned of only three that are still intact.

9.2.4 Professionals working within the system show signs of dissatisfaction.

a) There is an unusually high turnover rate for occupational health physicians.

This, along with the difficulty in recruiting physicians, is usually attributed to the lack of autonomy involved in practicing occupational health under the terms of the CSST-DSC contract. Doctors complain of being relegated to ticking off boxes on a form. There is also a substantial amount of paper work involved, and very little contact with the target population since intervention is the responsibility of the CLSC health and safety teams (mainly nurses and industrial hygiene technicians). Doctors are perhaps more affected by these conditions than other professionals, since they are accustomed to the greatest degree of autonomy in their work.

b) The primacy of the physician in occupational health is often challenged by the CLSC's.

The LSST has been accused of "medicalizing" the prevention of occupational diseases and accidents, on the grounds that a doctor's expertise is not really central to the accomplishment of that objective. In the CLSC's, other professionals and technicians are often responsible for all aspects of the health programs, and require the doctor only for a signature. In the context of a current movement to achieve greater professional status and autonomy for nurses, there is sometimes a resentment of the doctor's authority in this program, especially if the nurse is more experienced in occupational health than the doctor.

9.2.5 Relations within the network at the provincial level and the local level are not necessarily parallel.

a) The positions taken by the AHQ and the FCLSC have exaggerated the polarization of the network at the Provincial level.

It is the role of these organizations to defend their constituents' autonomy and other interests, for which the DSC's and the CLSC's rely on them. But the concerns of these organizations are not the primary concerns of the individual institutions they represent. For example, the disposition of the physician in charge of a workplace (médecin responsable) represents a structural ambiguity in the system that both the Provincial Committee-AHQ and the FCLSC want to resolve, each in their own favour. But in most local situations, relations between the doctors and the health and safety teams are not overtly problematic. Informal adjustments are made which are amenable to the particular individuals and the establishments involved.

b) Provincial strategies tend to be worked out in Montreal, where the problems are different and, in some case, exaggerated.

The Provincial Committee, the AHQ, the FCLSC and the CSST are all situated in Montreal, as well as 25% of the DSC's (8). On the other hand, only about 60% of the CLSC's planned for Montreal have been established (approx. 30). This alone creates different dynamics, since there are constant changes as the network develops, and several CLSC's are in an embryonic stage. As a consequence, there are areas where the requirement to decentralize is ambiguous, and the CRSSS of Region 6A has been a bit more ambitious than others in terms of facilitating relations between DSC's and CLSC's. The upshot is that the provincial associations are not close to the realities outside of Montreal, and tend to address political issues more than operative issues. Attempts are being made to correct this situation. For example, in contract negotiations with the CSST the Provincial Committee is raising the problem of the ratio of health professionals to workers in the broad geographical expanses of the peripheral regions.

9.2.6 The Ministry lacks credibility within the network in relation to the occupational health dossier.

MAS's Occupational and Environmental Health Services has been ineffectual, due to lack of support from higher levels of the Ministry. This situation has existed since 1977, when the occupational health dossier was awarded to Pierre Marois and MAS was relegated to playing an auxiliary role. The Ministry took the position then that the dossier was the responsibility of another Minister, and therefore it did not find either the funds or the political will to boost the network's profile or to support it in its relation with the CSST. As a result, most efforts on the part of Occupational and

Environmental Health Services to co-ordinate the network or to provide leadership in the CSST-MSSS Joint Committee have been futile. Examples: a) In the CSST-MAS Joint Committee, MAS was for years represented by the head of Occupational and Environmental Health Services alone, an office much below that of the CSST representatives that he faced on the committee, b) the MSSS Provincial Coordinating Committee organized by Occupational and Environmental Health Services died quickly when the DSC's Provincial Committee withdrew its participation after four meetings.

9.3 Scenarios for the Near Future

The LSST was born in an era when public discourse with respect to health and safety in the workplace was both inspired and expressed by the unions. In the six years since that time, the socio-economic and political climates have undergone a significant shift. The ideological position of employers and management has remained unchanged - employers are responsible for their organizations and employees, and should therefore have sole responsibility for developing the type of health services of their choice, or none at all. But today, this argument is more in line with public sympathies and concerns. The Liberal government has been elected on a pledge to revive the economy through the encouragement of private enterprise. The employers are seen as leaders and their concerns are highly respected.

The current situation in the domain of occupational health and safety is highly uncertain. In the past six months, there has been a new President and Director General at the CSST, who has placed a moratorium on health programs for Group III industries, while she evaluates the system and makes recommendations for the reorganization of health services; the CPQ is campaigning at all levels for the complete privatization of occupational health services, and appears to have some support from many quarters for at least a partial privatization; the Minister of Labour has announced impending changes to the occupational health and safety system and has struck a task force to which the Ministry of Health and Social Services has sent an observer; the structure of the MSSS has just been reorganized, with possible significance for liaison between network establishments; the CLSC's have once again been placed on "hold" by the MSSS while an evaluation of their role is conducted; and Occupational and Environmental Health Services of MSSS is about to report on the conclusions of two advisory committees, one which was mandated to make recommendations regarding the Occupational Health

And Safety Act, and the other regarding the Standard Contract.

In light of these uncertainties, it is clearly not the time to draw conclusions about the future of public health network involvement in occupational health and safety policy. The most that we might do on the basis of the preceding analysis, and given what we have learned about the social forces within the system and its key features, is to speculate on the possible changes that may be contemplated. In the following scenarios, then, we have tried to answer these questions: What are the elements of the system that may be played with to reorganize or reorient the participation of the public health network in occupational health? What are some of the possible consequences of tampering with each of these?

9.3.1 Working within the present parameters

We might first consider the scenario if formal changes to the policy do not touch those elements of the system that directly affect health services. The current process, in which the DSC's Provincial Committee is gaining strength and status in alliance with the AHQ, and its direct relation with the CSST, would continue, with an accompanying loss of autonomy and dilution of the mission of the CLSC's. This "degeneration" of the role of the CLSC's would occur more slowly if the CSST chooses to intervene by priority problems rather than priority industrial groups, since such a shift would tend to ease certain contradictions within the CLSC organizations. But as long as the CH-DSC's remain responsible for occupational health, it is unlikely that the CLSC's will become more than "service points" in the near future. The dossier would remain problematic for the CLSC's in terms of bureaucratic demands, style of intervention, integration with other programs, and in terms of organizational autonomy. From the point of view of the CSST, however, this may imply a gradual improvement in the situation, since its recent collaboration with the DSC's Provincial Committee has been productive in its terms.

9.3.2 Modification of the Standard Contract

A second scenario envisages changes to the standard contract between the CSST and the Ministry. The changes may be minor, for example, to the effect that MSSS approval be required for any CSST decision that affects the network as a whole. This would imply that the MSSS would have to involved in decisions regarding any reorganization of health services, or major budgetary adjustments. Such a limited change to the contract may have the perverse effect of exacerbating the problem of dual authority. Or the changes to the contract may be much more significant, such that the CSST budget for health services be transferred to the Ministry rather than the hospitals. The Ministry would then be responsible for coordinating the dossier. This would likely result in a more important role for the CRSSS, which might distribute the budget on the regional level, and would therefore participate more actively in assuring the integration of occupational health with other public health programs. It might ensure a continued role for the CLSC's, and greater legitimation for their style of intervention.

Although a significant change to the standard contract could raise the profile of the Ministry's set of game rules considerably, and would likely shift the current balance of power within the network from the AHQ to the MSSS, the extent to which it would influence the content of occupational health intervention is not clear. It would depend on the degree of commitment the upper echelons of the Ministry had to occupational health. The CSST would remain ultimately in charge of the entire policy, as stipulated in the Act, and without strong negotiation on the part of the Ministry, it would attempt to retain control of content, schedules, the ratio of health professionals to workers, and so on. In the end, the developments brought about by changes to the standard contract alone may not radically change reality in the field.

9.3.3 Modifications to the "Politique Cadre"

In another direction altogether, the Ministry might agree to modify or withdraw the politique cadre. The catalyst for such a move would be a government decision to partially privatize occupational health services, by altering article 116 of the Act to permit the DSC's to sub-contract with private doctors or clinics as well as other establishments of the public health network. The objective would be to introduce flexibility into a system which is currently constrained by a CLSC monopoly over the production of health programs. This change is strongly favoured by the AHQ, and therefore, by the DSC's Provincial Committee, whose control over the means of production would be greatly increased. They suggest that the advantage of this move would be more efficient services due to the introduction of an element of competition. But the true cost of privatized medicine may in fact be much higher unless the DSC controls the clinics' activities to the same extent that it does the activities of the CLSC's; the object would be to ensure the practice of a public health approach. Is this type of control of the private sector possible?

9.3.4 Major Modifications to the Occupational Health and Safety Act

a) The Occupational Health and Safety Act could be modified in terms of structurally separating prevention and compensation.

This was a model that had been strongly favoured by the public health network throughout the development of the policy, and it would appear from the preceding analysis that the concerns of those favouring a separation have been confirmed. The community health element of the system is struggling to stay alive and well. A strong case might be made for the Ministry of Health and Social Services to appropriate full control over occupational health services on the grounds that under the authority of the CSST bureaucracy and its board of directors, the objectives of the policy are jeopardized. As opposed to the situation outlined in (2) above, the Ministry would then be responsible for determining content and mechanisms of prevention, as well as the co-ordination of the program.

This alternative would not eliminate the problem of "two masters", but it would remove the problem from the field to the extent that all network establishments would be accountable to the Ministry alone. But the Ministry would have to work in concert with the CSST, who would finance prevention. At the upper levels, then, a new process of political negotiation and compromise would determine the rules of the game. These compromises, like those which framed the current policy - and like the politique cadre - may create a whole new set of constraints in the field, and a renewal of the informal adjustments which have so significantly marked the current system.

b) The Act could be modified to create more significant privatization of the system than envisioned in 9.3.3 above.

As a result of political pressure and in an effort to appear more cost-efficient, the demands of the employers may be met, if not entirely, then to a significant degree. If companies were permitted to provide their own health services, which they paid for directly, a whole new role for the public network would be implied (assuming that some role would indeed be maintained). The most likely scenario along these lines opens up the right for larger companies to hire private health services, or groups of companies to set up their own private clinics. The only role of the DSC would then be to approve and monitor these services, as currently outlined in articles 131 and 132 of the LSST. Obviously, if this were their only role, their budget would be minimal and most of their staff would move to the private domain.

However, it is likely that only the largest companies would be prepared to set up private services at their own cost. Certainly the medium and small enterprises would still want to rely on public services, and in these enterprises, especially where there are no unions, the CLSC's might play an important role. In the final analysis, the workers in large corporations would have their unions to depend on, while the workers in smaller organizations would depend on the CLSC's. While the DSC's would retain their role in planning, research and evaluation, the CLSC's might in fact be able to secure greater autonomy under these conditions.

But it is important to question the long-term efficiency of such a system. It is unlikely that private services would maintain a public health approach to occupational health - in fact, almost impossible, since the population which is the object of a public health approach is inevitably greater than the population of a single enterprise. Private health services, even if controlled by parity health and safety committees, would comply with the interests of both unions and management to provide visible services to individual workers, including regular examinations, testing, and so on. Individualoriented medicine cannot is not adapted to eliminating risks at their source. In this sense, and in terms of the use of hospital and laboratory services, a private system is ultimately much more expensive than a public system. A return to the pre-1979 situation poses a threat to the public health network, but also a serious threat to the original objectives of the Occupational Health and Safety Act.

CHAPTER X

OPTIONS AND RECOMMENDATIONS

The breadth of the recommendation which we are about to propose is limited by the scope of the research. Since we have focused on the public health network, to the exclusion of the CSST and especially the workplace - where the beneficiaries of the system are located - it is to be expected that our recommendations will be guided mainly by our observations regarding the functioning of that network. When in 1979, the CSST found itself at the head of a novel and complex system requiring the introduction of new structures and procedures in a highly sensitive organizational environment, it was expected that changes and adjustments would follow. Some significant ones are even now being suggested by the President of the CSST. The recommendations which follow will hopefully contribute to this process of readjustment.

Despite our focus on the functioning of the health network, we cannot avoid turning our attention at this point to the relation between the public health network and workplace. This necessity is imposed by the objectives of the LSST, which must serve as our guide and starting point.

The objectives of the Act are as follows:

1. The elimination, at the source, of dangers to the health, safety and physical well-being of workers (LSST, art.2).

2. The promotion of worker and employer participation in the realization of the first objective, as well as the participation of workers' and employers' associations (LSST, art.2).

3. The promotion of the right of workers and employers to training, information and counselling services in matters of occupational health and safety, especially in relation to the work environment (LSST, art.10.1, art.50).

4. The promotion of the worker's right to receive preventive and curative health services relating to the risks to which he or she may be exposed (LSST, art.10.2).

To what extent can the conclusions of the present research lead to recommendations which will, first and foremost, enhance the possibility of attaining the above objectives? We have made a number of observations about the dynamics, or social forces, which currently determine the strategies and decisions of the various actors within the public health network. It has become evident that certain of these forces have either blocked or diverted the development of a **network-workplace dynamic** in occupational health which had evidently been envisioned by the legislation. Our analysis of network dynamics suggests that a long-term, integrated public health approach to risk-related intervention and prevention in the workplace, has been jeopardized in part by short-term efficiency interests of the CSST and its board of directors.

More specifically, we have observed that:

1. The Ministry of Health and Social Services has not been committed, especially in the upper echelons, to the promotion of occupational health as an integral element of its public health policy.

2. The exceptional CH-DSC mandate in occupational health, which imposes direct financial and administrative accountability to the CSST rather than the Ministry, has distorted established network orientations and patterns of complementarity, and engendered an overriding concern with institutional interests within the network.

3. Decision-making regarding occupational health objectives, programs and planning has become concentrated in the CSST central office, whose link to the highly decentralized public health network is another centralized structure, the AHQ.

4. The general mission of the CLSC's to respond to local and specific needs, and their expertise in mobilizing groups to take charge of their own health and social conditions, is

> wasted and risks being "diluted" through their centrally controlled and circumscribed participation in the occupational health and safety system.
>
> 5. The authority and supervisory role granted the physician under the current system (LSST, arts. 117 - 126) appears to be organizationally and functionally misplaced, in terms of the ensemble of objectives mentioned above.

Given the objectives of the legislation, and these general observations on the functioning of the network, what options exist to improve the occupational health and safety system? In the following exercise, we will speculate on three possible directions that might be followed, indeed, that have been suggested at some time by one participant or another. Unlike the "scenarios" outlined in the previous chapter, each of these models represents an "ideal" as opposed to an assessment of possibilities given the current state of affairs. But as we shall see, each has its problems.

10.1 Model 1: The Status Quo

According to the DSC's and the AHQ, the current dynamics of the system have fairly well achieved an equilibrium that will permit a re-focusing of attention on occupational health objectives. Relations between the DSC's Provincial Committee for occupational health and safety and the CSST have been normalized via the AHQ, so that there has been a recent improvement in co-operation at both the administrative and the professional levels. Furthermore, relations between the CLSC's and the DSC's have also normalized, with the two institutions finding themselves in agreement over remaining "irritants" in the system. The DSC's have gained experience in managing the dossier which should not now be discarded. As with all new policies, the achievemnt of this equilibrium has taken some time, and it would be expensive folly to dismantle or radically change the system at this point.

This line of thought may be characterized by the popular maxim: "if it works, leave it alone". But the definition of "working" is a highly bureaucratic one, related to the smooth functioning of the "means", regardless of "ends". The DSC's have made considerable compromises in their earlier perception of occupational health issues in order to assert their status in the system. In fact, their influence with the CSST increased only when they agreed to play by CSST rules. For example, like the CSST, but in direct opposition to their pre-LSST position, the DSC's Provincial Committee now favours at least a partial privatization of the system to improve efficiency (presentation by Louis Drouin, Nov. 6, 1986).

Through the direct accountability of the DSC's to the CSST in this dossier, the CSST has effectiviely been able to create the "parallel health system" that it sought in the late 1970's. The questions we would want to pose regarding this option, then, are not very different from those we will pose regarding the next.

10.2 Model 2: CSST Appropriation of Occupational Health Services

From one point of view, there is good cause to reconsider the once-abandoned idea of placing full and direct responsibility for occupational health services in the hands of the CSST. The necessity of having to work with the numerous and relatively autonomous institutions of the public health network has resulted in delays, diversions, power struggles, over-bureaucratization and general inefficiency with respect to the production of occupational health services. Furthermore, for the health network, occupational health is one of a whole constellation of programs to administer, while for the CSST, it is the main priority. Efficient management and expertise are therefore more likely to be fostered at the CSST. For these reasons, the idea that it would be more efficient to use the existing health system rather than a parallel occupational health system under the CSST, has not proven valid.

While it is true that occupational health is but one public health program being handled by the health system, it is misleading to suggest that for the CSST, it is a priority. Only 2.5% of the CSST budget is devoted to occupational health services. The setting and collection of employers' premiums, the payment of compensation, and even inspection all have greater priority than health services. On the other hand, occupational health accounts for nearly 20% of the budgets of some health network establishments.

It is true, however, that the Ministry of Health and Social Services has not shown the same concern for the development of occupational health as it has for the development of those programs for which it is directly accountable. But we must equally question whether the provision of preventive health services is more of a priority for the board of directors of the CSST.

On the question of efficiency, there is little evidence that greater CSST control would guarantee greater efficiency. We might point to the slow start for sector-based associations and especially health and safety committees, as well as the generally poor quality of prevention programs (L. Jacques, 1986;), all of which have been under the direct auspices of the CSST.

Finally, this option must be assessed in terms of its likely consequences. It would appear that a certain privatization of health services, either in the form of employer-financing and/or in the form of contracting with private clinics, is likely to accompany the removal of occupational health from the public health network. Is this a desireable development? Is it more likely to promote the objectives of the LSST than is the current approach of public intervention and supervision? Will the long-term efficiency of the policy be of concern to private practitioners and employers?

10.3 Model 3: MSSS Appropriation of Responsibility for Occupational Health

Another alternative, also rejected at the time that the LSST was being elaborated, was to separate prevention from compensation. This had been recommended on the grounds that prevention in the "public health" sense was bound to be compromised by an agency whose central function was that of an insurance company, and who answered to private sector interests. For occupational health policy to be effective, it had to become an element of a global public health policy, and its programs integrated into the public health system. The extent of autonomy sought for occupational health varied: some felt it should be publicly funded so as to be completely freed from the influence of employers. Others felt that employers should foot the bill for occupational health, but should have no influence on how it was organized.

The problems with these solutions are more obvious today than they were in 1978. With the necessity to maintain, if not decrease public spending, and the political constraints against tax increases, especially in the corporate sector, the CSST is the only practicable source of funding for the policy. Companies are simply financing public services that they would otherwise pay for directly. But if they paid directly, they would control the production of those services. Is it possible to argue that, though they finance occupational health, there should be no accountablility to them? Would such a system promote the objectives of the LSST, to encourage employer sensitivity to and participation in occupational health and safety? If responsibility for prevention, or even for health services, were placed totally in the hands of the MSSS, might it not lead to over-professionalization, and discourage the organization of prevention in the workplace? Would it not be removing from the work sphere, an issue of primary interest to workers?

Other problems of a more administrative nature had also been raised in opposition to MSSS control over occupational health services. It had been argued that the public health system was too decentralized, too inefficient, too "uncontrollable" to handle the dossier effectively. Today, however, many of the "growing pains" in the network have been worked out, and it represents a model of decentralization that has yet to be established in other areas of social policy. Why then has our research exposed a system ridden with institutional rivalry and "power struggles"? The evidence suggests that to a large extent, these processes can be attributed to the "multi-sector" character of occupational health policy, which imposes constraints and compromises on the functioning of the public health establishments. In addition, we must accept that a period of institutional adjustment is required for any new policy to be integrated into a system.

10.4 Model 4: Sector-based Decentralization

One of the major complaints from employers' groups regarding the current occupational health services - aside from questions of "production level" - is that they are not sensitive to the particular needs and working conditions of each industrial sector. This ostensibly lies behind the difficulty in penetrating both BTP (construction and public works) and mining. From the side of the employees, there is still a large degree of ignorance regarding the LSST, especially where there are no unions. Health and safety committees are slow to be organized in the workplace, and where they exist, they have no decision-making power, and are easily manipulated by management.

The LSST envisaged a central role for sector-based associations in animating joint health and safety committees at the level of the workplace, through the provision of training, information and counselling with respect to prevention. But there is as yet little integration of these associations into the CSST-DSC-CLSC system, and the anticipated _prise en charge par le milieu_ is floundering.

This fourth option, then, would entail a transfer of decisionmaking power from the public sector to the private sector - represented by joint union-management associations and workplace committees, rather than employers. The sector-based associations would be responsible for organizing the provision of appropriate health services to their establishments, funded through the CSST. Since most of the decisions currently taken by the CSST central and the DSC/AHQ would then be taken at the sectorial level, health services would be more specific to the industrial group in question, and the active participation of health and safety committees would be facilitated.

This type of reorganization would likely be the catalyst for the rapid development of occupational health and safety clinics, administered by joint committees and contracted by sector-based associations.

Occupational health professionals would be directly accountable to the interests of unions and management. On the one hand, this is more promising than a total privatization in which they would be accountable to those who paid them, namely, the employers. But do we have any evidence that negotiated agreements between union and management will favour the main objective of the LSST: the elimination of dangers at their source? Or, like the board of directors of the CSST, do the associations mainly seek more services for their constituents? This system ultimately suffers from the same problem of any privatized system: in the long run, it is likely to be much more costly in terms of RAMQ and laboratory expenses.

Sector-based decentralization does provide a sound opportunity for a public health approach, including the development of expertise with respect to groups of industries, and the possibility of dealing with populations of workers. But will sector-based associations be able to ensure adequate availability of occupational health services across the province? And given general perception of the poor quality of prevention programs, would CSST ratification of health programs adequately ensure their quality vis a vis policy objectives?

Finally, the CSST has been reluctant to negotiate specific contracts at the regional level with 32 DSC's; thus the entrance of the AHQ into the picture, as representative of the CH-DSC's. What then would be the outcome of having to contract with an unlimited number of sector-based associations for the provision of health services? ? Would the board of directors of the CSST come to represent the sector-based associations to the CSST, that is, to itself? Would an apparently radical decentralization perversely result in the greatest possible centralization, effectively obstructing any significant local participation?

10.5 Our Option: A Focus on Sector Linkages

These four broad options have been elaborated to suggest the possible orientations that our recommendations might take, and of course, to indicate the complexity of considerations involved. **Given the objectives of the LSST and the conclusions of our research, none of the four appear to be sufficiently nuanced. Each tends to favour the interests of one set of institutional actors, either directly or indirectly, and usually at the expense of the ultimate goals and beneficiaries of the system.**

On the basis of the findings of our research, we have defined our own objectives more specifically as:

1. Promotion of the objectives of the LSST, including prevention at source and participation of workers and employers at the local level and regional levels.

2. Consolidation of those elements of the system where significant expertise and experience has been accumulated over the last ten years.

3. Diffusion of inter-organizational tensions which have characterized this dossier, within the network and between the network and the CSST.

4. Activation of a public sector/private sector dynamic, that is, of interaction between the system and the field.

5. Decentralization of the system, to allow for significant participation and cooperation at the local level.

6. Accountability to the government, not the CSST, for the content and management of occupational health services.

In view of these objectives, our option envisions a continuation of joint CSST-Public health network responsibility for occupational health - but with greater autonomy for the network than currently exists. This entails the negotiation of a contract directly between the CSST and the Ministry of Health and Social Services.

There are a number of positive consequences that would follow such a change. First, it redirects accountability for health services to the government, thus freeing these services from the interests of unions and employers' associations. At the same time, it preserves a public health approach, which in the long-term is far more efficient than privatized services both economically, and in terms of the objectives of the law.

Secondly, increased MSSS control over occupational health will help to diffuse the "two masters" syndrome which encourages the development of obstructive inter--organizational tensions. The institutions of the network will be freed to integrate occupational health into their public health programming, through the adaptation of processes that have developed for other public health programs. In consideration of this objective, we suggest that the official role of the physician in charge of a work establishment (le medecin responsable) be discarded as both contrary to the normal functioning of network establishments, and as implying an unnecessary "medicalization" of the occupational health dossier.

Thirdly, a transfer of control to the Ministry will favour greater decentralization in the occupational health dossier, given the relative autonomy of the network's establishments. While maintaining a province--

wide system for the provision of services, there will be more room for sensitivity and adjustment to local and regional industrial characteristics.

This option takes advantage of all those positive developments that have already occured within the system, including the development of expertise in the public health network, and organizational structures and procedures to implement the provision of services. It does not require the institution of new structures and regulations, but creates conditions favourable to further development and change.

Alone, however, this reform would not guarantee the development of a _prise en charge par les gens du milieu_. In fact, there would be a danger of a continuing professionalization of occupational health, and a focus on _intervention in the workplace_ rather than _interaction with the workplace_. The public health network, after all, was originally intended to be a resource to workers and employers, and we feel that this role should be promoted.

Therefore, we are proposing that mechanisms for interaction between the system and the field be instituted in the form of formal linkages. In some regions, certain informal mechanisms have already been established, and have been perceived by the participants as a positive step. We would suggest, therefore, that the formation of regional committees (tables de concertation) be required, including the participation of DSC's, the regional offices of the CSST, and representatives of the sector-based associations. This is perhaps one way of integrating, as far as possible, sectorial planning and regional planning. It is also hoped that it would encourage the granting of greater autonomy to the CSST regional bureaux, so that they might contribute creatively to these committees.

Finally, in an effort to promote greater worker--employer participation at the level of the work establishment, and to encourage a constructive system/field relation, we would like to see the establishment of a completely new position, which we will call the "Multi--establishment prevention representative" (Représentant à la prévention multi-entreprise), or RPME. The RPME is a liaison between the private and public sectors, at the local or, in peripheral areas, the regional level. The job of the RPME is to facilitate communication between the enterprise and the public network, usually the CLSC team.

The RPME would be originally associated with a sector-based association, that is, he or she would be familiar with the characteristics, problems and needs of a particular set of industries. The job would include such activities as the encouragement of the formation of joint health and safety committees in work establishments, through the provision of training and information. In this sense, it is very much in concert with the originally-conceived function of the sector-based associations.

However, the RPME would be a major resource not only for the health and safety committees of the work establishments in a particular territory, but for the CLSC's teams, as well. For the CLSC's, the RPME would provide two sorts of services: first, he or she would provide information as needed regarding particular industries. Secondly, the RPME would facilitate intervention in the workplace, by familiarizing workers and employers with the specific objectives and role of the CLSC team.

The RPME would therefore be responsible for maintaining continuous contact with a group of work establishments in a given territory, all of the same industrial sector, and with the CLSC occupational health teams servicing those establishments. The CLSC teams would remain accountable to the ministry for the content and organization of these services. the RPME would be accountable to the sector-based association, but his or her responsibilities would be sufficiently vague - e.g., "continuous contact" - so as to encourage the animation of the milieu and of the relation between that milieu and the system designed to serve it. The establishment of this linkage would hopefully "humanize" what curently appears to some workers and employers to be a bureaucratic structure of "government experts" marginal to the workplace.

10.6 RECOMMENDATIONS

1. That occupational health services be defined and organized on the basis of a negotiated contract between the CSST and the Ministry of Health and Social Services.

2. That the planning, programming, delivery and evaluation of occupational health services be carried out by the different establishments of the public health network (DSC's and CLSC's) as per their respective mandates.

3. That regional committees (tables de concertation) be established including representatives from the CSST, DSC and the sector-based associations.

4. That the position of "physician in charge of an establishment" (medecin responsable) be abolished.

5. That a wholly new position be created, which we will call the "Multi-Establishment Prevention Representative" (**"Répresentant à La Prevention Multi-Entreprise"**, or RPME).

5.1. The RPME is chosen by the health and safety committee of a work establishment - where one exists - from a list provided by the sectorbased association, and approved by the regional committee (table de concertation). Where no committee exists, the RPME may be appointed by the association.

5.2. The function of the Multi-Establishment Prevention Representative (RPME) is to act as liaison between the health and safety committees of a number of work establishments within a particular industrial sector, and the professionals of the public health sector (mainly CLSC teams).

5.3. The role of the RPME is to encourage the creation of health and safety committees in the workplace, to facilitate relations between the CLSC teams and both workers and employers, to serve as a resource person for both the CLSC's and the health and safety committees, and to promote the complementarity of health programs and prevention programs.

5.4. It is the responsibility of the RPME to maintain continuous contact with the CLSC's associated with the work estbalishments in his/her territory, and well as the workers and employers of those work establishments. He/she is to fulfill some of the responsibilities currently assigned to the physician in charge of a workplace (le medecin responsable), e.g., notify the CSST, employers, workers, and if necessary the DSC or CLSC of any deficiency or dangerous situation, and carry out regular visits to the workplace (LSST, arts. 123, 124, 125).

APPENDIX "A"

EXCERPTS FROM THE
ACT CONCERNING OCCUPATIONAL HEALTH AND SAFETY

(R.S.Q. S-2.1)

Loi sur la santé et la sécurité du travail

S-2.1

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Québec

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CHAPITRE VIII
LA SANTÉ AU TRAVAIL

SECTION I
LES PROGRAMMES DE SANTÉ ET LE CONTRAT TYPE

Programmes de santé et contrat type.

107. La Commission élabore:

1° des programmes de santé au travail devant s'appliquer sur les territoires ou aux établissements ou catégories d'établissements qu'elle détermine;

2° un contrat type indiquant le contenu minimum des contrats devant intervenir entre la Commission et les centres hospitaliers où existe un département de santé communautaire aux fins de la mise en application des programmes de santé.

Entente avec ministre des affaires sociales.

Un projet de programme de santé ou de contrat type doit être soumis, pour entente, au ministre des affaires sociales.

1979, c. 63, a. 107.

Entrée en vigueur.

108. Un programme de santé et le contrat type visés dans l'article 107 entrent en vigueur sur approbation du gouvernement.

1979, c. 63, a. 108.

Contrat avec centre hospitalier.

109. La Commission conclut, avec chaque centre hospitalier où existe un département de santé communautaire, un contrat aux termes duquel le centre hospitalier s'engage à assurer les services nécessaires à la mise en application des programmes de santé au travail sur le territoire délimité par le contrat ou aux établissements ou catégories d'établissements qui y sont identifiés.

Conformité avec contrat type.

Le contrat doit être conforme aux dispositions du contrat type; il peut également prévoir les priorités en matière de santé au travail applicables au territoire ou aux établissements ou catégories d'établissements qui y sont identifiés, compte tenu des fonctions du conseil régional des services de santé et des services sociaux au sens de la Loi sur les services de santé et les services sociaux.

Validité du contrat.

Ce contrat est valide à compter de la date à laquelle il est déposé auprès du conseil régional de la région où est situé le centre hospitalier.

1979, c. 63, a. 109.

Budget.

110. La Commission établit chaque année un budget pour l'application du présent chapitre. Elle attribue une partie de ce budget à chaque centre hospitalier où il existe un département de santé communautaire conformément au contrat intervenu avec ce centre hospitalier.

Rémunération du personnel.

À même la partie du budget qui lui est attribué, le centre hospitalier rémunère le personnel professionnel, technique et clérical, à l'exception des professionnels de la santé au sens de la Loi sur l'assurance-maladie (chapitre A-29), et assume les coûts reliés aux examens et analyses de même qu'à la fourniture de locaux et d'équipements conformément à la Loi sur les services de santé et les services sociaux.

1979, c. 63, a. 110.

Rémuneration du médecin.

111. Le médecin responsable des services de santé d'un établissement choisi conformément à l'article 118 de même que les autres professionnels de la santé au sens de la Loi sur l'assurance-maladie qui y fournissent des services dans le cadre des programmes visés dans le présent chapitre sont rémunérés par la Régie de l'assurance-maladie du Québec, selon le mode d'honoraires fixes, d'honoraires forfaitaires, du salariat, de la vacation ou de la vacation spécifique conformément aux ententes conclues en vertu de l'article 19 de cette loi.

1979, c. 63, a. 111.

SECTION II

LE PROGRAMME DE SANTÉ SPÉCIFIQUE À UN ÉTABLISSEMENT

Programme de santé.

112. Le medecin responsable des services de santé d'un établissement doit élaborer un programme de santé spécifique à cet établissement. Ce programme est soumis au comité de santé et de sécurité pour approbation.

1979, c. 63, a. 112.

Contenu.

113. Le programme de santé spécifique à un établissement doit notamment prévoir, compte tenu des programmes de santé visés dans l'article 107 applicables à l'établissement et des contrats intervenus en vertu des articles 109 et 116, les éléments suivants:

1° les mesures visant à identifier les risques pour la santé auxquels s'expose le travailleur dans l'exécution de son travail et à assurer la surveillance et l'évaluation de la qualité du milieu de travail;

2° les activités d'information du travailleur, de l'employeur ainsi que, le cas échéant, du comité de santé et de sécurité et de l'association accréditée sur la nature des risques du milieu de travail et des moyens préventifs qui s'imposent;

3° les mesures visant à identifier et à évaluer les caractéristiques de santé nécessaires à l'exécution d'un travail;

4° les mesures visant à identifier les caractéristiques de chaque travailleur de l'établissement afin de faciliter son affection à des tâches qui correspondent à ses aptitudes et de prévenir toute atteinte à sa santé, sa sécurité ou son intégrité physique;

5° les mesures de surveillance médicale du travailleur en vue de la prévention et du dépistage précoce de toute atteinte à la santé pouvant être provoquée ou aggravée par le travail;

6° les examens de santé de pré-embauche et les examens de santé en cours d'emploi prévus par règlement;

7° le maintien d'un service adéquat de premiers soins pour répondre aux urgences;

8° l'établissement et la mise à jour d'une liste des travailleurs exposés à un contaminant à partir des registres tenus par l'employeur.

1979, c. 63, a. 113.

Copie du programme à la Commission.

114. Une copie du programme de santé spécifique à l'établissement doit être transmise à la Commission ainsi qu'au chef du département de santé communautaire.

1979, c. 63, a. 114.

Services de santé.

115. Les services de santé pour les travailleurs d'un établissement sont fournis dans l'établissement.

Services de santé.

Ils peuvent également être fournis dans un centre hospitalier ou un centre local de services communautaires. Ils peuvent enfin être fournis ailleurs lorsque le chef du département de santé communautaire croit que cela est nécessaire en raison de la non-disponibilité des autres locaux.

1979, c. 63, a. 115.

Contrat de service entre centres hospitaliers.

116. Un centre hospitalier où existe un département de santé communautaire peut conclure avec un autre centre hospitalier ou un centre local de services communautaires un contrat de service aux termes duquel ce dernier s'engage à fournir des services de santé spécifiques à un établissement.

Validité. Ce contrat est valide à compter de la date à laquelle il est déposé auprès du conseil régional de la région où est situé le centre hospitalier ou le centre local de services communautaires qui le conclut.

1979, c. 63, a. 116.

SECTION III

LE MÉDECIN RESPONSABLE DES SERVICES DE SANTÉ D'UN ÉTABLISSEMENT

Médecin. **117.** Un médecin peut être nommé responsable des services de santé d'un établissement si le centre hospitalier dont le département de santé communautaire assure ces services a, conformément à la Loi sur les services de santé et les services sociaux, accepté sa demande d'exercer sa profession aux fins de l'application du présent chapitre.

1979, c. 63, a. 117.

Choix du médecin. **118.** Le comité de santé et de sécurité choisit le médecin responsable. S'il n'y a pas accord entre les représentants de l'employeur et ceux des travailleurs au sein du comité, la Commission désigne le médecin responsable après consultation du chef du département de santé communautaire.

Médecin désigné. S'il n'y a pas de comité, le chef du département de santé communautaire désigne le médecin responsable.

1979, c. 63, a. 118.

Mandat. **119.** La nomination d'un médecin responsable par un comité est valable pour quatre ans. Une nomination faite par la Commission ou le chef du département de santé communautaire est valable pour deux ans.

1979, c. 63, a. 119.

Requête pour démettre un médecin. **120.** Les représentants des travailleurs ou les représentants de l'employeur sur le comité de santé et de sécurité, le comité lui-même ou, s'il n'y a pas de comité, une association accréditée ou l'employeur, ou, s'il n'y a pas d'association accréditée, dix pour cent des travailleurs peuvent adresser une requête à la Commission des affaires sociales afin de démettre de ses fonctions auprès d'un établissement le médecin qui y est responsable des services de santé.

Appel.

De même, un médecin dont un centre hospitalier où existe un département de santé communautaire n'a pas accepté la demande visée dans l'article 117 ou à l'égard de qui, il n'a pas renouvelé son acceptation peut interjeter appel de la décision devant la Commission des affaires sociales.

Motifs.

Une requête en vertu du présent article doit être fondée sur le défaut de qualification, l'incompétence scientifique, la négligence ou l'inconduite du médecin responsable.

1979, c. 63, a. 120.

Procédure.

121. La requête et l'appel visés dans l'article 120 sont présentés conformément à la Loi sur la Commission des affaires sociales (chapitre C-34).

1979, c. 63, a. 121.

Ressources professionnelles, techniques et financières.

122. Le médecin responsable des services de santé d'un établissement procède, en collaboration avec le chef du département de santé communautaire, à l'évaluation des ressources professionnelles, techniques et financières requises pour les fins de la mise en application du programme de santé spécifique à l'établissement.

Application du programme de santé.

Il voit également à la mise en application du programme de santé spécifique de l'établissement.

1979, c. 63, a. 122.

Rapport d'activités et de déficience des conditions de santé.

123.* Tout en respectant le caractère confidentiel du dossier médical et des procédés industriels, le médecin responsable doit signaler à la Commission, à l'employeur, aux travailleurs, à l'association accréditée, au comité de santé et de sécurité et au chef du département de santé communautaire toute déficience dans les conditions de santé, de sécurité ou de salubrité susceptible de nécessiter une mesure de prévention. Il doit leur transmettre, sur demande, un rapport de ses activités.

1979, c. 63, a. 123.

Information au travailleur.

124. Le médecin responsable informe le travailleur de toute situation l'exposant à un danger pour sa santé, sa sécurité ou son intégrité physique ainsi que de toute altération à sa santé.

1979, c. 63, a. 124.

Visite des lieux de travail.

125. Le médecin responsable doit visiter régulièrement les lieux de travail et prendre connaissance des informations nécessaires à la réalisation de ses fonctions.

1979, c. 63, a. 125.

Accès au lieu de travail.

126. Le médecin responsable ou la personne qu'il désigne a accès à toute heure raisonnable du jour ou de la nuit à un lieu de travail et il peut se faire accompagner d'un expert.

Accès aux informations nécessaires.

Il a de plus accès à toutes les informations nécessaires à la réalisation de ses fonctions notamment aux registres visés dans l'article 52. Il peut utiliser un appareil de mesure sur un lieu de travail.

1979, c. 63, a. 126.

SECTION IV

LE CHEF DU DÉPARTEMENT DE SANTÉ COMMUNAUTAIRE

Fonctions.

127. Le chef du département de santé communautaire est responsable de la mise en application sur le territoire qu'il dessert des contrats visés dans les articles 109 et 116; il doit notamment:

1° voir à l'application des programmes de santé spécifiques aux établissements;

2° collaborer avec le comité d'examen des titres du conseil des médecins et dentistes et avec le conseil d'administration du centre hospitalier pour l'étude des candidatures des médecins désirant oeuvrer dans le domaine de la médecine du travail conformément à la présente loi et à ses règlements et à la Loi sur les services de santé et les services sociaux et à ses règlements;

3° coordonner l'utilisation des ressources du territoire pour faire effectuer les examens, analyses et expertises nécessaires à la réalisation des programmes de santé;

4° colliger les données sur l'état de santé des travailleurs et sur les risques à la santé auxquels ils sont exposés;

5° s'assurer de la conservation du dossier médical d'un travailleur pendant une période d'au moins vingt ans après la fin de l'emploi du travailleur ou quarante ans après le début de l'emploi, selon la plus longue durée;

6° effectuer des études épidémiologiques;

7° évaluer les programmes de santé spécifiques aux établissements et faire les recommandations appropriées à la Commission, aux médecins responsables et aux comités de santé et de sécurité concernés;

8° transmettre à la Commission les données statistiques sur l'état de santé des travailleurs et tout renseignement qu'elle peut exiger conformément à la présente loi ou les règlements;

9° visiter les établissements du territoire et prendre connaissance des informations nécessaires à la réalisation de ses fonctions.

1979, c. 63, a. 127.

Droits.

128. Le chef du département de santé communautaire ou la personne qu'il désigne jouit des droits visés dans l'article 126.

1979, c. 63, a. 128.

Confidentialité du dossier médical.

129. Sous réserve du paragraphe 5° de l'article 127, la conservation et le caractère confidentiel du dossier médical du travailleur sont assurés selon la Loi sur les services de santé et les services sociaux et les règlements adoptés en vertu de cette loi concernant le dossier d'un bénéficiaire.

Communication du dossier.

Le médecin doit, sur demande, communiquer ce dossier médical au travailleur ou, avec l'autorisation écrite de ce dernier, à toute personne désignée par le travailleur.

1979, c. 63, a. 129.

SECTION V

LA RECONNAISSANCE DE CERTAINS SERVICES DE SANTÉ

Demande de reconnaissance des services de santé.

130. Dans les 90 jours de l'entrée en vigueur du règlement qui détermine que les services de santé doivent être fournis aux travailleurs de l'établissement, l'employeur peut présenter une demande de reconnaissance des services de santé qui existaient dans son établissement le 20 juin 1979 et qui ont été maintenus jusqu'à la date de la présentation de la demande.

Demande au centre hospitalier.

Cette demande est adressée au centre hospitalier ayant un département de santé communautaire sur le territoire duquel se trouve l'établissement.

Assentiment des représentants des travailleurs.

Elle ne peut être présentée par l'employeur que s'il a obtenu l'assentiment des représentants des travailleurs au sein du comité de santé et de sécurité ou, s'il y a plusieurs comités, du comité pour l'ensemble de l'établissement, ou, à défaut de comité, de la ou des associations accréditées ou, à défaut d'association accréditée, de la majorité des travailleurs de l'établissement.

1979, c. 63, a. 130.

Recommandation.

131. Si, après examen de la situation, le chef du département de santé communautaire est d'avis que les services offerts dans l'établissement sont équivalents aux services de santé prévus par la présente loi et les règlements, il peut recommander au conseil d'administration du centre hospitalier de reconnaître ces services et, s'il y a lieu, les conditions de cette reconnaissance.

1979, c. 63, a. 131.

Examen annuel.

132. Le chef du département de santé communautaire examine annuellement la situation et il recommande au conseil d'administration du centre hospitalier d'annuler la reconnaissance ou de la renouveler et, s'il y a lieu, les conditions de ce renouvellement.

1979, c. 63, a. 132.

Rémunération du personnel de santé.

133. À l'exception des professionnels de la santé au sens de la Loi sur l'assurance-maladie, le personnel oeuvrant dans les services de santé reconnus par le centre hospitalier est rémunéré par l'employeur. L'employeur assume également les coûts reliés aux examens et analyses de même qu'à la fourniture des locaux et de l'équipement.

1979, c. 63, a. 133.

Personnel intégré à un centre hospitalier.

134. À l'exception des professionnels de la santé au sens de la Loi sur l'assurance-maladie, le personnel oeuvrant dans les services de santé visés dans l'article 130 est intégré au sein d'un centre hospitalier ou d'un centre local de services communautaires lorsque:

1° les services de santé de l'établissement ne sont pas reconnus par le centre hospitalier ou la reconnaissance n'est pas renouvelée;

2° le membre du personnel travaillait dans une proportion de cinquante pour cent de son temps à des tâches directement reliées à la santé au travail; et

3° il y a impossibilité pour le membre du personnel d'être replacé adéquatement à l'intérieur de l'établissement en fonction de ses qualifications professionnelles et des besoins de l'établissement.

1979, c. 63, a. 134.

Responsabilité du ministre.

135. Le ministre des Affaires sociales est responsable de l'intégration du personnel au sein d'un centre hospitalier ou d'un centre local de services communautaires dans les cas prévus par l'article 134. Il utilise notamment les ressources internes au secteur des Affaires sociales pour favoriser la meilleure intégration du personnel.

1979, c. 63, a. 135.

Avis de l'employeur.

136. L'employeur qui n'entend pas présenter une demande de reconnaissance des services de santé visés dans l'article 130 doit en aviser le ministre des Affaires sociales dans les 90 jours de l'entrée en vigueur du règlement prévu par l'article 130.

Cessation des services de santé.

En tout temps, après l'expiration des 90 jours de l'entrée en vigueur de ce règlement, l'employeur qui n'entend plus maintenir les services de santé qui ont fait l'objet d'une reconnaissance de la part d'un centre hospitalier doit donner un préavis de quatre mois au ministre des Affaires sociales.

Intégration du personnel.

Dans ces cas, le personnel oeuvrant dans les services de santé de l'établissement affecté par la décision de l'employeur est intégré au sein d'un centre hospitalier ou d'un centre local de services communautaires conformément aux articles 134 et 135.

1979, c. 63, a. 136.

CHAPITRE IX

LA COMMISSION DE LA SANTÉ ET DE LA SÉCURITÉ DU TRAVAIL

SECTION I

CONSTITUTION

*****

Nomination des membres et du président.

141. Les membres du conseil d'administration de la Commission sont nommés par le gouvernement. À l'exception du président, ils sont désignés de la façon suivante:

1° sept membres sont choisis à partir des listes fournies par les associations syndicales les plus représentatives; et

2° sept membres sont choisis à partir des listes fournies par les associations d'employeurs les plus représentatives.

1979, c. 63, a. 141.

*****

Observateur.

145. Le ministre des affaires sociales nomme un observateur auprès du conseil d'administration de la Commission. Cet observateur participe à toutes les réunions du conseil d'administration sans droit de vote.

1979, c. 63, a. 145.

SECTION II

LES FONCTIONS DE LA COMMISSION

Fonctions. **166.** La Commission a pour fonction d'élaborer, de proposer et de mettre en oeuvre des politiques relatives à la santé et à la sécurité des travailleurs de façon à assurer une meilleure qualité des milieux de travail.

1979, c. 63, a. 166.

Fonctions. **167.** En outre des autres fonctions qui lui sont attribuées par la présente loi, les règlements ou toute autre loi ou règlement, la Commission exerce notamment les fonctions suivantes:

1° établir les priorités d'intervention en matière de santé et de sécurité des travailleurs;

2° accorder son concours technique aux comités de santé et de sécurité et son aide technique et financière aux associations sectorielles;

3° élaborer et mettre en oeuvre un programme d'aide à l'implantation et au fonctionnement des mécanismes de participation des employeurs et des travailleurs dans le domaine de la santé et de la sécurité du travail;

4° identifier les priorités et les besoins de la recherche en matière de santé et de sécurité du travail;

5° effectuer ou faire effectuer des études et des recherches dans les domaines visés dans les lois et règlements qu'elle administre,

APPENDIX "B"

OCCUPATIONAL HEALTH AND SAFETY IN QUEBEC:
A CHRONOLOGY

OCCUPATIONAL HEALTH AND SAFETY IN QUEBEC: A CHRONOLOGY

PRE-1970

Document: "Mémoire au gouvernement du Québec de la FTQ" (1959), cites steady increase in work accidents and demands a public enquiry into the administration of the CAT.

Strike of miners at Campbell-Chibougamou over dangerous working conditions (1960)

Adoption of the hospital insurance law (1961).

Wood Report published by CAT, recommending certain internal administrative changes (1962).

Workers at Union Carbide in Beauharnois demand, but are refused, an enquiry into dangerous working conditions (1962).

Workers at Wabush Mines in Pointe Noire demand, but are refused, an enquiry into dangerous working conditions (1966).

Media publicity of Turcotte Interchange tragedy leads to public indignation (1967).

1970

Adoption of la Loi sur l'assurance-maladie.

Media publicity over the death of a miner at Gaspé Cooper of Murdochville. For the first time in Québec, a company was found guilty of criminal negligence.

United States adopts the Occupational Health and Safety Act (OSHA).

Britain sets up the Committee on Health and Safety at Work (under Lord Robens) to develop a new health and safety policy.

1972

Adoption of the LSSS, establishing the CLSC's and the "community health" approach (multidisciplinarity, participation, prevention, etc.).

Creation of _les Services de protection de l'environnement_, with minor responsibilities in the area of occupational health.

Saskatchewan adopts new occupational health and safety legislation.

Publication of the Robens Report in Britain, recommending a structural separation of inspection and prevention, and putting an accent on parity participation within enterprises.

1973

Minault Report published by CAT, in which public dissatisfaction with CAT is attributed to poorly trained CAT employees' insensitivity to the work milieu and the reality of work accidents.

Mc Donald Report on community health leads to the establishment of 32 DSC's in hospital centres throughout the province.

1974

The Labour Minister initiates an interministerial committee for health and safety in the workplace, the point of which is to institute some coherence into a patchwork system (April, 1974).

CAT creates a task force of its own, under the auspices of Alphonse Riverin, to review its objectives and structures (May, 1974).

The Labour Minister hires a firm of consultants to study the role of inspection in the field of occupational health and safety.

CAT creates the Service de prévention (Sept. 1974).

Interministerial committee produces a draft of a general law which would redistribute activities among the Minister of the Environment, MAS, the Minister of Labour and Manpower, and the Minister of Natural Resources.

CLSC's are relegated to a "period of reflection" while MAS contemplates their future.

Creation by MAS of the Department of Community Services, whose major responsibility is the CLSC's.

DSC's are specifically mandated by MAS to "s'associer aux préoccupations et aux politiques nouvelles du ministre (des affaires sociales) en matière de médecine du travail et d'intervenir dans le cas de travailleurs victimes ou ménacés d'intoxication industrielle". (MAS Annual Report, 1974-75).

1975

FTQ organizes a colloquium on accident prevention (Jan. 1975)

Expro accident generates enormous publicity, many official and semi-official enquiries.

FTQ presents a major brief to the minister of Labour and Manpower (April, 1975) denouncing the CAT, and calling for a coherent occupational health policy under a single ministry, with a strong focus on prevention.

Publicity surrounding health risks to asbestos workers as a result of the asbestos workers'strike (spring, 1975).

Adoption of the "Act respecting indemnities for victims of asbestosis and silicosis in mines and quarries" (June, 1975).

Announcement in the National Assembly by the Minister of Labour, Jean Cournoyer, that "des modifications majeures seront apportées l'automne prochaine à la Loi des accidents du travail" (June, 1975)

The Riverin Report is published by CAT (July 1975), making recommendations for a complete reform of CAT functions.

MAS task force set up to develop the elements of an integrated occupational health policy, which would form the basis for new legislation.

Documents: Majority and Minority reports by task force appointed to evaluate the CLSC's (June, 1975). Claude Forget re-establishes priorities of the CLSC's, promoting "efficient administration" and "the production of services".

Heads of DSC's are named medical officers ("médecins hygiénistes") in the sense of article 21 of the Act respecting Industrial and Commercial Establishments (Oct. 1975).

Creation by MAS of the department of Occupational and Environmental Health Services (Nov. 21, 1975).

Britain adopts new health and safety legislation based on the Robens Report of 1972.

1976

Minister of Labour promises, in the National Assembly, a complete revision of SST legislation within the current year.

Conclusions of MAS task force are outlined in 1975 Annual Report of MAS, published in March, 1976, on the principles of a new occupational health policy.

Major revisions, during 1976, of health and safety legislation in Alberta, Manitoba, Ontario and New Brunswick.

Defeat of the Liberals and election of a Parti Québecois government (Nov. 15, 1976).

1977

New Ministerial Appointments: Pierre Marois, Minister of State for Social Development; Denis Lazure, MAS; Jacques Couture, Minister of Labour and Manpower.

Marois is assigned the mandate to develop a policy and elaborate a White Paper on occupational health.

Tessier is replaced by Robert Sauvé as PDG of CAT (February, 1977).

Sauvé is mandated by the Minister of Labour to proceed with the regionalization of CAT (May 5, 1977).

Couture is replace by Pierre-Marc Johnson as Minister of Labour (July 6, 1977).

MAS assigns 16 positions to DSC's for "coordinator of occupational health".

Document: "L'Hygiène du travail au Canada - Situation présente", June, 1977, Dept. of Health and Welfare, Canada.

Document: "Les Composantes d'une politique de la santé et de la sécurité des travailleurs: Rapport de mission en Yugoslavie et en Roumanie", July 1977 (MAS).

Document: "Proposition du CLSC-Soc de Sherbrooke concernant la réforme sur la protection de la salubritésécurité-santé dans les milieux de travail" (Oct. 1977).

Minor amendments made to the Law respecting work accidents and the Law respecting indemnities for victims of asbestosis and silicosis.

Regionalization of CAT complete by the end of 1977.

1978

Document: "Propositions de la Fédération des CLSC concernant la réforme gouvernementale sur la protection de la salubrité, de la sécurité et de la santé dans les milieux de travail" (March, 1978).

Establishment of a standing task force at the Féderation des CLSC to promote the development of CLSC intervention in the domain of SST.

A colloquium is held on "The University and Occupational Health". Document: "Besoins des CLSC et des DSC en médecine du travail" (March, 1978).

Document: "Le role et les activités des départements de santé communautaire (CH-DSC's) en santé au travail", MAS.

Document: The White Paper, "Santé et sécurité au travail: politique québecoise de la santé et sécurité des travailleurs", (October, 1978).

1979

Jean-Louis Bertrand is appointed to CAT in the capacity of vice-president, prevention (March, 1979).

Following eight months of heated debate in the National Assembly, Bill 17, based fairly closely on the White Paper, is officially tabled (June 20, 1979).

Sixty-nine briefs are presented to la Commission permanente du travail et de la main-d'oeuvre, during public hearings on Bill 17.

MAS allocates another 16 positions to the DSC's for coordinators in SST, as well as 20 positions for assistant coordinators.

Document: "Rapport synthèse de 10 programmes de CLSC en santé au travail, 1978-1979", Féderation des CLSC.

Adoption of La loi sur les normes du travail.

Bill 17, with some amendments, is adopted by the National Assembly and becomes Chapter S-2 of the Revised Statutes of Québec, An Act Respecting Occupational Health and Safety (December 21, 1979).

1980

Creation of the CSST (March 13, 1980). Robert Sauvé, president of CAT, is named PDG of the CSST.

An agreement is signed between the CSST and existing inspection services, transferring authority - but not financing - to the CSST and its regional bureaus (May 23, 1980).

The first sector-based association is created, for health and social service workers (June, 1980).

The CSST draws up the standard contract between the CSST and DSC's, and presents it to MAS.

The CSST-MAS Joint Standing Committee is created.

The CSST ad hoc committee on prevention defines Group I industries as top priority with respect to preventive intervention.

Document: "La loi sur la santé et la sécurité du travail: implication des centres hospitaliers ayant un département de sante communautaire", P. Marois, Minister of State for Social Development.

Document: "Les CLSC et la Loi 17 sur la santé et la sécurité du travail: avis." - Féderation des CLSC.

Pierre Marois moves from Minister of State for Social Development to Minister of Labour, replacing Pierre-Marc Johnson (Nov. 6, 1980).

1981

Document: "Les CLSC: Un parachèvement qui s'impose" (April 3, 1981).

The PQ regains power in the provincial elections. Pierre-Marc Johnson replaces Lazure as Minister of Social Affairs (April, 1981).

Beginning of economic recession: Severe budget cuts for the CLSC's.

The board of directors of the CSST finalizes the contents of the first specific contract submitted to the AHQ for signing by the hospitals. Objective: to set up base teams in the DSC's.

The Standard Contract between the CSST and MAS is signed (July 1981).

The DSC's Provincial Committee on Occupational Health is formed.

1982

The CSN, at its annual congress, decides to boycott the board of directors of the CSST.

The CSST adopts the regulation regarding prevention in May, 1982, and it comes into effect in July, 1982.

More budget cuts for CLSC's.

The board of directors of the CSST finalizes the 1982 contract between the CSST and the DSC's (August, 1982), for developing health services in Group I establishments.

AHQ and FCLSC hold preliminary negotiations regarding DSC-CLSC sub-contracts for front-line occupational health services.

Document: "Politique-cadre d'administration des services de santé au travail de première ligne" (August, 1982).

The AHQ reveals a model contract to serve as a basis for negotiations between DSC's and CLSC's (September 16, 1982). The FCLSC distributes its own copy with comments on unacceptable clauses.

Marois is replaced as Labour Minister by Raynald Frechette (Dec.17, 1982). Marois becomes Minister of Manpower and Social Security.

1983

Most DSC organizational plans for the decentralization of resources are complete and are submitted to the CRSSS's for approval where necessary.

A contract to develop health programs for Group II industries is drawn up by the CSST in June, 1983.

Document: "Le Programme de santé spécifique à un établissement, un guide d'élaboration et de mise en application", published in May 1983 by the CSST, to serve as a reference guide for DSC and CLSC SST teams.

The CSN, at its annual congress, decides to participate again in the board of directors of the CSST.

"Le Centre patronal de santé et sécurité au travail" is created by the CPQ, with a view to providing informational services to both associations and individual establishments.

The CSST departments of prevention and inspection are merged, under the vice-presidency of J-L Bertrand.

Most DSC-CLSC service contracts are signed by the summer of 1983.

Pierre Marois resigns (Nov. 1983).

The proposal for Bill 42 - An act respecting work accidents and professional diseases - is deposited in the National Assembly by Frechette, Minister of Labour (Nov. 22, 1983).

DSC colloquium, "Pour une mission en santé", erupts in demands for new leadership and reorganization.

1984

The CSST adopts the regulation concerning Health and Safety Committees, (Jan. 1984).

La Commission permanente du travail hears approximately 50 briefs regarding Bill 42 (Feb - March 1984).

Document: "L'Approche communautaire et la santé au travail dans le réseau des affaires sociales", work paper from DCS-CHUL, May, 1984.

A new version of Bill 42 is deposited with the National Assembly, with greatly reduced regulatory powers for the CSST, (June 16,1984).

Louis Drouin takes leadership of the DSC's Provincial Committee.

1985

The CSST makes a formal request to MAS that four DSC's be placed under trusteeship.

Negotiations begin between AHQ and the ADDSC regarding amalgamation. The AHQ reorganized its Community Health Division.

Massive demonstrations against Bill 42 are held throughout the province despite revisions of June 1984 (March, 1985).

Regulation making Group III industries a SST priority comes into effect April 29, 1985. A contract is drawn up by the CSST.

Québec Chamber of Commerce proposes the abolition of the CSST in a brief to Frechette.

L'Association pour la Santé Publique du Québec organizes a colloquium on health and safety in the workplace. Document: "Colloque, Approche Communautaire en santé et sécurité du travail", May, 1985.

Adoption of Bill 42 by the National Assembly in greatly amended form, May 23, 1985.

Document: "Projet d'un cadre de référence pour une approche communautaire en santé au travail", final work paper by MAS and DSC-CHUL, still waiting approbation by MAS since August, 1985.

FCLSC announces in the CSST-MAS Joint Standing Committee that it will not sign Group III contracts unless certain changes are made.

Document: "Bilan et perspectives en santé et sécurité au travail", published by the AHQ with DSC's Provincial Committee, regarding the mandate exercised by the DSC's.

Liberals defeat the PQ and proceed to form a new government (Dec. 2, 1985).

1986

Simultaneous creation of three task forces by Bourassa government (Jan. 1986):

- The Task Force on the privatization of public organisms, under Pierre Fortier

- The Task Force on the rationalization of government functions and organisations, under Paul Gobeil

- The Task Force on deregulation of the private sector, under Reed Scowan

Beaudry Report on industrial relations is made public (Jan. 20, 1986).

Rochon Commission mandate modified to focus on financing and decision-making in the realm of health and social services, with a particular view to possibilities for privatization (Feb. 1986).

Document: "Privatisation de sociétés d'Etat: Perspectives et orientations", Fortier's initial report on privatization (Feb. 24, 1986).

President of the Treasury Board, Gobeil announces the supression of financial aid to the CSST in amount of 22 M$, earmarked for inspection and prevention (March 25, 1986).

Federal employees gain the right to refuse dangerous work, and are required to set up Health and Safety Committees wherever there are more than 20 workers (April 1, 1986).

Sauvé resigns under pressure, April 20, 1986. New PDG of the CSST, Monique Jérome-Forget, is nominated April 21, and takes over on May 1 for a 5-year mandate.

A moratorium is announced on health services for Group III industries. Contracts have not yet been signed.

Paradis, Minister of Labour, announces major legislation in SST for the coming autumn (June 16, 1986).

MAS creates 2 advisory committees, one to make recommendations re: the LSST, the other to make recommendations re: the Standard Contract.

Appeal costs traditionally paid by the Ministry of Justice are added to the CSST budget, a total of 5 M$. (June 19,1986)

Jérome-Forget declares that the CSST is ready to participate in a reorganisation of the health and safety régime (July 7, 1986). The CSST sets up a task force to study the implications of deregulation and the privatization of government organisations.

The CSST and the CPQ collaborate in presenting a colloquium on the privatization of occupational health. (Nov. 1986)

Paradis, Minister of Labour, strikes a task force to study possible reforms to occupational health and safety policy.

APPENDIX "C"

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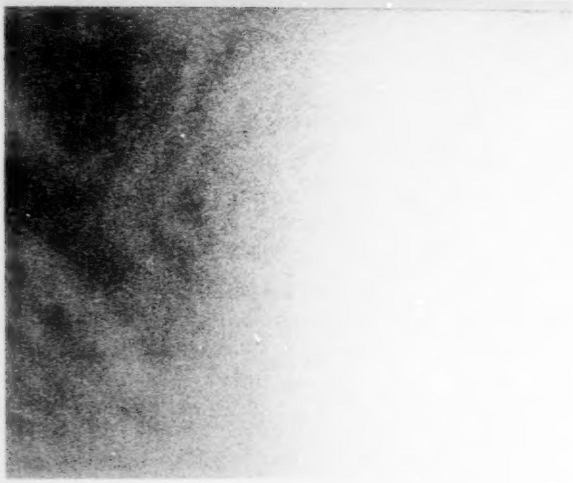
[1] Ce document comprend 4 rapports publiés en un seul volume sous le titre "Le développement de la technologie"



Le programme de recherche a constitué, avec la consultation [illegible] la consultation d'experts, l'une des trois sources d'information [illegible] principaux programmes d'activités de la Commission d'enquête [illegible] services de santé et les services sociaux.

Ce programme avait notamment pour objectifs de contribuer à la compréhension des problèmes actuels du système des services de santé et des services sociaux, de vérifier l'impact de diverses hypothèses de solutions et, à plus long terme, de stimuler la recherche dans ce domaine.

Afin de rendre compte de ce programme de recherche, la Commission a décidé, sur recommandation du comité scientifique, de publier une collection des synthèses critiques et des recherches. Le présent document s'inscrit dans le cadre de cette collection.